Bundle BCU Audit Committee 16 December 2025

1 09:30 - PRELIMINARY MATTERS

1.1 09:30 - AC25.154 Welcome and Apologies - Verbal
Paul Lambert, Chair

1.2 09:31 - AC25.155 Declarations of Interest - Verbal
Paul Lambert, Chair

1.3 09:32 - AC25.156 Unconfirmed minutes of meeting held on 21.10.25 - for approval
Paul Lambert, Chair
AC25.156 Audit Committee minutes 21.10.25 unconfirmed V0.2 (Public)

1.4 09:35 - AC25.157 Matters arising and action log - Attached
Paul Lambert, Chair
AC25.157 Summary Action Log _Public

2 09:45 - GOVERNANCE

2.1 09:45 - AC25.158 Update on Outstanding Audit Recommendations - Presentation (Chief Operating Officer)
Tehmeena Ajmal, Chief Operating Officer in attendance
AC25.158 COO Open Audit Recommendations and CRR BAF Risks v2

2.2 10:15 - AC25.159 Progress on the Consultant Job Planning Internal Audit Report - Paper
Clara Day, Executive Medical Director in attendance
AC25.159a Consultant Job Planning Update v4
AC25.159b BCU-2526-27 Final Internal Audit Report Consultant job plan followup

2.3 10:35 - AC25.160 Clinical Audit Improvement Plan - Paper
Clara Day, Executive Medical Director in attendance
AC25.160a Tier 1 Clinical Audit Forward Plan and Tier 2 Clinical Audit Plan - December 2025 V0.4
AC25.160b Appendix 1 Clinical Audit Forward Plan - 2025-2026 Final V0.3

2.4 10:55 - AC25.161 Statutory Compliance Report - Paper
Glesni Driver, Head of Statutory Compliance and Inquiries in attendance
AC25.161a Compliance report 16.12.2025 v1.00
AC25.161b Compliance report App 1 - IA Open Unsatisfactory v1.00
AC25.161c Compliance report App 2 - IA Open Limited Assurance v1.00
AC25.161d Compliance report App 3 - IA - closure summary v1.00
AC25.161e Compliance report App 4 - AW open v2.00
AC25.161f Compliance report App 5 - AW recs closure summary v1.00
AC25.161g Compliance report App 6 All overdue patient safety v2.00
AC25.161h Compliance report App 7 - MDs v1.00
AC25.161i Compliance report App 8 WHC v1.00

2.5 11:05 - AC25.162 Policy Management Process - Paper
Glesni Driver, Head of Statutory Compliance and Inquiries in attendance
AC25.162a Revised Policy Management Process v2.00
AC25.162b RPMP App 1 Policy Approval Route v2.00
AC25.162c RPMP App 2 BCU Policy v2.00

2.6 11:15 - AC25.163 Board Assurance Framework - Paper
Nesta Collingridge, Head of Risk Management in attendance
AC25.163 Board Assurance Framework Report December 2025 v2

2.7 11:25 - AC25.164 Corporate Governance Report - Paper
Philippa Peake-Jones, Head of Corporate Governance in attendance
AC25.164 Corporate Governance Report

AC25.164a Corporate Governance Report - Appendix 1 Audit Committee Forward Work (Live Version as at 09.12.25)

2.8 11:30 - BREAK

3 11:45 - FINANCE

3.1 11:45 - AC25.165 Conformance Report - Paper
Russ Caldicott, Executive Director of Finance
AC25.165 Conformance Report - Q2 2025-26 FINAL (002)

3.2 11:55 - AC25.166 Post Payment Verification Update - Paper
Russ Caldicott, Executive Director of Finance
AC25.166a PPV Mid Year Audit Committee Report _2025-2026
AC25.166b Appendix BCuHB Mid-year PPV Report 2025-2026

4 12:00 - INTERNAL AUDIT

4.1 12:00 - AC25.167 Internal Audit Progress Report - Paper
Dave Harries, Head of Internal Audit
(Appendices provided in supporting papers pack)
AC25.167a IA progress report December 2025
AC25.167b IA progress report December 2025

5 12:20 - EXTERNAL AUDIT

5.1 12:20 - AC25.168 External Audit Progress Report 4960A2025 - Paper
Andrew Doughton, Audit Manager, Audit Wales
AC25.168 Audit Committee Update 16122025 Audit Wales report 4960A2025
AC25.168b BCU Planned Care Management Response - approved - Oct 2025

5.2 12:40 - AC25.169 Audit Wales - BCUHB Awyr Las 24/25 Audit Plan 5141A2025
Audit Manager, Audit Wales
AC25.169 Awyr_Las_2025_Audit_Plan 5141A2025

6 12:50 - COUNTER FRAUD

6.1 12:50 - AC25.170 Local Counter Fraud Service Report - Paper
Russ Caldicott, Executive Director of Finance
Danielle Timmins, Head of Counter Fraud in attendance
AC25.170 PUBLIC -Counter Fraud Audit Committee Progress Report

7 13:00 - CLOSING BUSINESS

7.1 13:00 - AC25.171 Agree items for referral to Board / other Committees - Verbal
Paul Lambert, Chair

7.2 13:02 - AC25.172 Review of meeting effectiveness - Verbal
Paul Lambert, Chair

7.3 13:04 - AC25.173 Date of next meeting - 17.02.26

7.4 13:05 - Resolution to exclude the Press and Public
"Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Audit Committee
held in Public on 21 October 2025
in the Boardroom, Carlton Court, St Asaph and via Team

Committee Members Present	
Name	**Title**
Urtha Felda	Independent Member (Vice Chair of Audit Committee)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member *(via Teams)*
Paul Lambert	Independent Member
In Attendance	
Russell Caldicott	Executive Director of Finance
Nesta Collingridge	Head of Risk Management
Clara Day	Executive Medical Director *(part meeting)*
Glesni Driver	Head of Statutory Compliance and Inquiries
Linda Dyson	Regional Risk Manager, Central *(observer)*
Fflur Jones	Performance Audit Lead, Audit Wales
Dave Harries	Head of Internal Audit
Nicola Jones	Deputy Head of Internal Audit
Phylis Makurunje	Aspiring Board Member
Jane Moore	Executive Director of Public Health Part meeting
Sharon Scott	Head of Emergency Preparedness, Resilience and Response *(part meeting)*
Helen Stevens-Jones	Director of *(part meeting)*
Danielle Timmins	Head of Counter Fraud *(via teams – part meeting)*
Pam Wenger	Director of Corporate Governance
Committee Support	
Philippa Peake Jones	Head of Corporate Governance
Laura Jones	Acting Corporate Governance Manager

PRELIMINARY MATTERS

AC25/131 Welcome and Apologies

Apologies were received for Dyfed Edwards and Stuart Keen.

The Vice Chair welcomed Paul Lambert, Independent Member to the meeting noting that Paul will become the Chair of the Audit Committee commencing from the next meeting being held in December 2025.

AC25/132 Declarations of Interest

No declarations of interest were raised at the meeting.

AC25/133 Unconfirmed Minutes of Meeting held on 19 August 2025

It was agreed that the minutes of the meeting held on 19 August 2025 were a true and accurate record.

AC25/134 Matters Arising and Action Log

Members received the action log and noted progress against the actions.

Matters Arising and Action Log: Contracted Patient Services Review

- In relation to action AC25/109.1 it was noted that the Director of Corporate Governance has discussed this with the Chief Executive as the Director of Performance and Commissioning has now left the organisation. It was confirmed that this will be transferred over to a different Directors portfolio to ensure the recommendations relating to the Commissioning Assurance Framework are actioned.

Statutory Compliance Report: Consultant Job Planning Review

- In relation to action AC25/110.1 it was confirmed that the new Executive Medical Director has recently commenced in post and has been made aware of the issues relating to the progress of this review. The Executive Medical Director has been given some time to review this area of concern and will present a report to the next Committee meeting in December 2025.

Internal Audit Progress Report: Scheme of Reservation and Delegation

- In relation to action AC25/69.2 it was noted that as the Director of Performance and Commissioning has now left the organisation the action relating to the Scheme of Reservation and Delegation will be addressed by including relevant contracts and documents in the Finance Report that is submitted to the Board to ensure visibility of the required documentation.

Concerns were raised around specific items relying on individuals which leads to lack of pace around certain actions. It was suggested that there is a need to ensure tasks can be picked up by team members to take areas of work forward where required.

The Committee reviewed the action log and agreed to close the following actions, after consideration of the updates and papers presented to the Committee (where required): AC25/111.1, AC25/115.1, AC25/115.2, AC25/116.1, AC25/117.1, AC25/64.1, AC25/64.2, AC25/67.2, AC25/69.1, AC25/70.1, AC25/04.1, AC24/124.3 and AC24/121.2.

GOVERNANCE

AC25/135 Update on Outstanding Audit Recommendations

Members received the report and the Executive Director of Public Health and the Head of Emergency Preparedness, Resilience and Response highlighted:

- The Internal Audit Report received reflects the amount of progress that has been made in relation to Emergency Preparedness, Resilience and Response over the past 18 months since Sharon Scott has been in post.

- Emergency Preparedness, Resilience and Response plans have now been developed and are being exercised and tested to ensure staff can respond when necessary.
- Further work is required in relation to business continuity plans to ensure significant plans are in place across the organisation and staff have an understanding of their responsibilities if a Major Incident occurs to make sure the Health Board can deal with specific situations if they arise.
- In relation to the recommendations from the Internal Audit Report, the team were confident that the actions could be completed by the deadlines required.
- A business continuity dashboard has been established and a scoping exercise is underway to identify the amount of plan required across the Integrated Health Communities and Corporate Services. The dashboard will allow the team to monitor compliance and workshops are also taking place to assist staff in developing their plans.
- On call training continues to be delivered and significant progress has been made noting that 70% of staff on bronze, silver and gold rotas have now completed the required training with further plans in place to deliver training for the remaining 30%.
- External training sessions have also been taking place with multi agency partners and there is a need to ensure clinical training programmes are also developed to focus on business continuity issues.
- The relevant policies and procedures have been revised and approved for use.
- In relation to the relevant risks, every plan within the Health Board should be tested, this takes a significant amount of time and resource however the team continue to have a focus on this area of work.

In discussing the report, the Committee:

- Noted the significant progress that has been made from an Internal Audit perspective and highlighted that areas such as Corporate Services remain at risk, particularly in relation to a cyber attack and this is an area that requires focus and progress. It was confirmed that the team are working closely with the Digital, Data and technology team to provide support in developing their business continuity plans.
- Referred to the cyber risk confirming this is included in the Corporate Risk Register as a high risk for the organisation and requires robust business continuity plans to be in place to ensure the Board are assured. There is also a need to look at the broader risks included in the Corporate Risk Register to ensure they are aligned to the Board Assurance Framework and it was suggested an update is presented to the next meeting.
- Confirmed that the team will continue to work closely with Internal Audit and will escalate any adjustments to timescales if required as well as monitoring the ability to deliver training exercises at pace across the Health Board.

Action:

- **AC25/135.1** An update on the Cyber risk in relation to the Corporate Risk Register to be discussed at the next meeting of the Committee.

It was resolved that the Committee:

- **NOTED** the content of the presentation.

AC25/136 Statutory Compliance Report

Members received the report and the Director of Corporate Governance highlighted:

- The report notes progress against the Audit recommendations and where reviews have been rated as limited or no assurance, Executive Directors are being invited to attend the Committee to provide an update.
- Where recommendations are suggested for closure by management, evidence is reviewed by the relevant Executive Directors and Internal Audit to confirm whether the evidence is sufficient. There has been a lack of assurance in the past in relation to this process however it has now been revised and is more robust than other organisations.
- Amendments have been made to the style of the appendices and further work is required to ensure the information is comprehensible.
- The Director of Corporate Governance highlighted the open 'unsatisfactory' and open 'limited' recommendation to the Committee noting the progress that is being made and the actions required.
- The Committee were asked to approve the Audit Wales recommendations that have been put forward for closure.

In discussing the report, the Committee:

- Referred to the recommendations in relation to the Llandudno Hospital Orthopaedic Surgical Hub. It was confirmed that the Chief Executive has requested a review of Major Project Governance and Contractor Management to be undertaken and this will be shared at the next meeting in December 2025 if available.
- Highlighted the Public Interest Report issued by the Ombudsman and the implementation of a Commissioning Assurance Framework. It was noted that a revised timescale has been agreed with the Ombudsman and the Director of Corporate Governance agreed to follow this up outside of the meeting.
- Noted the amount of red and amber ratings querying whether the recommendations are too difficult to achieve. It was confirmed that the Directors are responsible for agreeing the initial actions, this has historically been an area of challenge and work is taking place with Internal Audit colleagues to list the evidence required at the sign off stage to provide clarity on the requirements.
- Queried 'open' Audit Wales recommendation relating to Urgent and Emergency Care and the work required with Local Authorities to facilitate discharges as no updates were provided. It was confirmed that the Chief Operating Officer is being asked to attend the next meeting in December 2025 and can address this as part of the update on open Audit recommendations.
- Referred to the 'open' limited recommendations relating to the Performance Management Framework and reporting as no updates were provided against these recommendations. It was confirmed that updates have been sought from the team however there is a limit on the amount of requests being made for updates to be provided. The current process consists of a manual process which is time consuming.

Actions:

- **AC25/136.1** A copy of the documentation in relation to the Major Project Governance and Contractor Management Review to be shared at the next meeting in December 2025.
- **AC25/136.2** Director of Corporate Governance to follow up the progress in relation to the implementation of a Commissioning Assurance Framework outside of the meeting and report back to the Committee.
- **AC25/136.3** Chief Operating Officer to refer to Audit Wales recommendation 1364 in relation to Urgent and Emergency Care when presenting to the Committee in December 2025.

It was resolved that the Committee:

- **NOTED** the content of the report.
- **APPROVED** the Audit Wales recommendations put forward for closure.

AC25/137 Revised Policy Management Process

Members received the report and the Director of Corporate Governance highlighted:

- Progress has been made to revise the policy management process however an interim report is being presented to the Committee for comment.
- The final version of the policy will come back to the Committee in December 2025 for onward approval by the Board in January 2026.
- The document has been shared with the Executive Committee and Internal Audit for comment and provides clarity on approval routes.

In discussing the report, the Committee:

- Noted the following comments relating to the policy:
  - Concern around whether the full impact assessment is too onerous.
  - Requested definitions in terminology are included to ensure the document is easy to understand.
  - Noted the importance of approval routes to ensure a timely process.
- Confirmed that the comments would be considered noting that the intention of the revision is to simplify the impact assessment process and streamline the current system to ensure clarity and simplicity.

Action:

- **AC25/137.1** Final version of the Policy Management Process to be presented to the Committee in in December 2025 for onward approval by the Board in January 2026.

It was resolved that the Committee:

- **NOTED** and **COMMENTED** on the proposed policy management process to enable to work on the consultation of the overarching policy.
- **NOTED** that following comments, the final Policy will be considered at the Audit Committee in December 2025.

AC25/138 Risk Management Framework

Members received the report and the Head of Risk Management highlighted:

- Minor revisions have been made to the framework and an escalation process has been developed for risks that require escalation to the Executive Committee and back to the Risk Management Group.
- Internal Audit reviewed the document last year and provided a substantial assurance rating.
- Board Members have had the opportunity to contribute to the document via a Board Development Session.

In discussing the report, the Committee:

- Suggested that the risks should be driven by the Board collectively rather than via the Executive Committee. It was confirmed that this was discussed during the Board Development Session and will be revised.
- Noted that the Board are required to review the risk appetite on an annual basis therefore both the Risk Appetite and Risk Management Framework will be presented to the Board in November 2025.

It was resolved that the Committee:

- **RECOMMENDED** endorsement of the Risk Management Framework for onward assurance for Board approval in November 2025.

AC25/139 Corporate Risk Register Report

Members received the report and the Head of Risk Management highlighted:

- Two Development Sessions have taken place with the Executive Committee to review the Corporate Risk Register and ensure the risks are strategic in nature.
- Recommendations were agreed to consolidate some of the corporate risks, those that were more operational in detail will sit under the Chief Operating Officer's Operational Leadership Team and a member of the Risk Team will provide support.
- Some new strategic risks have been developed in relation to modernising our infrastructure and timely patient access to safe and effective care however further work is required to ensure the risks contain the correct actions.
- A refined version of the Corporate Risk Register will be presented to the Board in November 2025.

In discussing the report, the Committee:

- Noted that there is a need for a line of sight for the operational risks to be escalated, the process is being discussed with Internal Audit and will be considered in further detail with the Executive Committee.
- Confirmed that the Board Assurance Framework has clear strategic objectives therefore there is a need to ensure all objectives being developed are smart to provide assurance to the Board as this will impact the clarity of the Board Assurance Framework.
- Referred to the risk relating to timely patient access noting the controls being put in place are not mitigations and there is a need to provide assurance that the controls are having an impact. It was confirmed that further work is required to strengthen controls and mitigations.

It was resolved that the Committee:

- **PROVIDED FEEDBACK**, **RECEIVED ASSURANCE** and **ENDORSED** the updated corporate risk register.

AC25/140 Corporate Governance Report

Members received the report and the Director of Corporate Governance highlighted:

- A Corporate Governance Report will be presented to all Committees going forward.
- Breaches against the Standing Orders between the period of April and September 2025 have been noted in the report. Some incidents relate to poor drafting of Board papers therefore a new report template is being developed alongside report writing training and additional tools to provide support in this area.
- A live update on the Declarations of Interest system has been provided, further work is required on the process and this is being discussed with Internal Audit.
- As part of the Integrated Medium Term Plan there was a commitment to develop a Governance Improvement Plan to measure progress. The plan is structured around key themes and responds to findings from internal and external assessments, including the Structured Assessment, Board Assessment, Internal Audit and Audit Wales reviews.

In discussing the report, the Committee:

- Highlighted that it is the responsibility of Directors and Managers to ensure staff complete their Declarations of Interest.
- Queried where procurement and financial governance fit with the Governance Improvement Plan. It was confirmed that this is an area that links in with the Standing Financial Instructions however further discussion on this with the Executive Director of Finance may be helpful.

It was resolved that the Committee:

- **NOTED** the breaches to the Standing Orders.
- **NOTED** the Declarations of Interests.
- **NOTED** and **COMMENTED** on the Draft Governance Improvement Plan 2025-27.
- **NOTED** the Summary of business considered in private session to be reported in public.
- **NOTED** the Forward Workplan.
- **RECEIVED** an update on the Mental Health and Society.

INTERNAL AUDIT

AC25/141 Internal Audit Progress Report

Members received the report and the Head of Internal Audit highlighted:

- The progress report is being presented to the Committee in the new format.
- Table 1 outlines the reviews that have been finalised during the reporting period noting that progress has been made in relation to Civil Contingencies and reported to the Committee.
- It has been agreed that reports issued as final during the reporting period are included in the supporting papers for the Committee to ensure members have sight of the reports for the information.

- An issue in relation to the Public Health review was raised regarding grant funding being used for fixed-term posts and this poses a significant risk.
- Processes are now in place in relation to the Patient Experience review however there is a need to focus on embedding learning at an operational level.
- The agreed actions in relation to the Consultant Job Planning review have not been addressed within the specified timescales and the Health Board's job planning compliance is currently at 43%, this is an issue that needs to be addressed.
- A number of follow up recommendations have been returned as the evidence being provided is not robust enough to demonstrate implementation.
- A number of additional reviews have been approved and noted in the report. Two further reviews have also been requested in relation to a Major Project Governance and Contractor Management Review and a review around the Centre for Mental Health and Society.
- The performance indicators highlight an issue with report turnaround times, the ability for managers to respond to draft reports and the lack of sufficient evidence being provided. It was confirmed that the Vice Chair has raised these issues via a letter to the Chief Executive following the last meeting and it was suggested this is taken further via a meeting with the relevant Committee members.

In discussing the update, the Committee:

- Welcomed the review on Major Project Governance and Contractor Management but raised concern as to whether the review of the Centre for Mental Health and Society will be substantive. It was noted that there have been issues procuring an independent reviewer therefore a review has been requested to identify whether there are any substantial issues that need to be addressed.
- Referred to the Patient Experience review querying how to address persistent problems in specific areas over a number of years. It was confirmed that the Patient Advice and Liaison Service are embedded in this area, the Citizen Experience Report that goes to the Board does include some of the information being captured and the Executive Director of Nursing and Midwifery is revising the People Experience Framework.

Consultant Job Planning

The review was discussed and it was noted that:

- The Executive Medical Director is aware of the delay and the Medical Director for the Integrated Health Community, West is now taking this forward.
- An agreed policy has previously been cowritten with the Local Negotiating Committee and the British Medical Association and is now locally owned. The policy has been presented to the Joint Local Negotiating Committee and the Medical Workforce Group and there is now a need to draft the document into a full policy by the end of the year.
- The policy will provide clarity around appeals processes and training needs assessments and will be aligned to a dashboard allowing teams to review information down into individual specialities.
- Wider discussion is required to progress this piece of work and new timescales are being established.

In discussing the update, the Committee:

- Queried the confidence of the team to achieve the timescales being set. It was confirmed that these have been proposed by the Medical Director for the Integrated Health Community, West who is leading on this work and is confident with the timescales. It was confirmed that if any dates need to be revised these will be submitted via the Audit Committee to ensure delivery.
- Going forward there will be a focus on developing job plans and confirming any changes to the structures and services.
- Noted that progress against the Consultant Job Planning review is being presented to the People and Culture Committee in December 2025 ahead of coming back to the Audit Committee following that meeting.
- Questioned whether this is a policy and structure issue or whether there are further issues surrounding this area of work. It was confirmed that there are a range of issues including protocols, productivity, culture and accountability in relation to clinical leadership and management.

Partnerships, Engagement and Communication Internal Audit Report
The review was discussed and it was noted that:

- A progress update has been provided highlighting the activity that has taken place since the audit was completed.
- The audit identified the need to strengthen governance arrangement, operational oversight and benefits realisation.
- As a result of this a consolidated delivery plan has been developed to align the improvement actions into a monitored programme and is being presented to the next meeting of the Planning, Population Health and Partnerships Committee.
- Quarterly monitoring meetings have now been established to review supporting evidence and highlight any areas of risk and the next phase is to standardise the Standard Operating Procedures utilised within the team.
- Assurance was provided that the implementation of recommendations remains on track and any associated risk are being managed.

Action:

- **AC25/141.1** Committee Chair, Vice Chair and Head of Internal Audit to meet with the Chief Executive to raise concerns around Internal Audit report turnaround times and the lack of sufficient evidence being provided.

It was resolved that the Committee:

- **RECEIVED** the progress report and **APPROVED** the amendments to the internal audit plan for 2025/26.

EXTERNAL AUDIT

AC25/142 External Audit Progress Report

Members received the report and the Performance Audit Lead highlighted:

- The Financial Audit Team have commenced planning arrangements for the audit of the Awyr Las Annual Report and Accounts.
- The review on Planned Care has been completed and was presented to the Audit Committee at its last meeting in October 2025.

- The thematic work on Urgent and Emergency Care has also been completed and the report is included in the papers for information.
- As part of the Structured Assessment, a deep dive review will take place into the investment in digital systems and work is taking place to agree the scope of this review.

In discussing the report, the Committee:

- Requested clarity in relation to the distinction between services including Same Day Emergency Care (SDEC), Urgent Primary Care Centres (UPCC) and Minor Injuries Units (MIU) querying how these services provide a bridge between Primary and Secondary Care to ensure staff and patients have a clear understanding of what services are available. It was confirmed that Audit Wales are doing a piece of work across Wales to establish the models being used in other areas however it was noted that there are pockets of information available but there is no overall clear picture that patients can refer to.
- Confirmed that Urgent and Emergency Care was discussed by the Board at the meeting in September 2025 and suggested this may be an area of specific focus where the Chief Operating Officer is invited to the Committee to discuss in further detail. It was agreed that the update from the Chief Operating Officer at the next meeting should include progress against Internal Audit recommendations as well as an update on this report and the recent Planned Care and Unscheduled Care reports.
- Noted the update on the National Fraud Initiative which is a UK wide Counter Fraud exercise conducted every two years. The exercise is underway and Audit Wales will conduct a high level assessment in collaboration with Counter Fraud colleagues.

Action:

- **AC25/142.1** Chief Operating Officer to join the December meeting to provide an update on the Internal Audit recommendations, the thematic work on Urgent and Emergency Care and the recent Planned Care and Unscheduled Care reports.

It was resolved that the Committee:

- **NOTED** the content of the report.

COUNTER FRAUD

AC25/143 Local Counter Fraud Service Report

Members received the update and the Head of Counter Fraud highlighted:

- The report notes the significant progress that has been made in relation to investigations with 16 cases proposed for closure during this quarter.
- Training compliance remains high and engagement continues with Counter Fraud clinics taking place and information being shared on BetsiNet which highlights an uplift in staff interaction.
- A proactive exercise has been concluded in relation to travel expenses, it was noted that no fraud was discovered however recommendations have been made for improvements.
- Two proactive exercises have commenced this quarter in relation to private patients being assessed on Health Board premises and direct payments for health budgets.

- A Task and Finish Group is being established to complete a Counter Farud risk assessment across the organisation with support from the Risk team.
- Funding has been agreed to appoint an additional Local Counter Fraud specialist with plans to appoint to the position by the end of December 2025.

It was resolved that the Committee:

- **CONSIDERED** and **NOTED** the contents of the report.

CLOSING BUSINESS

AC25/144 Agree Items for Referral to Board / Other Committees

There were no actions agreed for referral.

AC25/145 Review of Meeting Effectiveness

It was agreed that there had been good contributions to discussion from all members of the Committee.

AC25/146 Date of Next Meeting

Tuesday 16 December 2025, 9.30am

Resolution to Exclude the Press and Public

"Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Audit Committee Action Log (Public)

Updated 4.12.25

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			REMAIN OPEN			
1	**AC25/135.1**	21.10.25	**Update on Outstanding Audit Recommendations** An update on the Cyber risk in relation to the Corporate Risk Register to be discussed at the next meeting of the Committee.	Pam Wenger	Feb 26	**Remain Open** A deep dive into Cyber is planned to take place at the Planning, Public Health and Partnerships Committee on 15.1.26 (private session).
2	**AC25/136.1**	21.10.25	**Statutory Compliance Report** A copy of the documentation in relation to the Major Project Governance and Contractor Management Review to be shared at the next meeting in December 2025.	Pam Wenger	Feb 26	**Remain Open** **4.12.25** Review is underway.
3	**AC25/136.2**	21.10.25	**Statutory Compliance Report** Director of Corporate Governance to follow up the progress in relation to the implementation of a Commissioning Assurance Framework outside of the meeting and report back to the Committee.	Pam Wenger	Dec 25	**Remain Open** **1.12.25** Chief Executive confirmed at the Board meeting on 27.11.2025 that the Commissioning Assurance Framework was in draft.
4	**AC25/109.1**	19.08.25	**Matters Arising and Action Log** Director of Corporate Governance to discuss the Contracted Patient	Pam Wenger	Dec 25	**Remain Open** **4.12.25** Progress update pending **11.09.25** Director of Corporate

			Services Review with the Chief Executive, circulate a briefing outside of the meeting and further consideration of progress to be reported at the next Committee meeting.			Governance to discuss with the Chief Executive and report back to the Committee.
5	**AC25/110.1**	19.08.25	**Statutory Compliance Report** Progress on Consultant Job Planning to be closely monitored by the People and Culture Committee and assurance provided back to the Audit Committee in due course.	Clara Day	Dec 25	**Remain Open** **4.12.25** Agenda item AC25.159 (Noting also discussed at P&C Committee on 4.12.25 (Item PC25.133)). **06.10.25** This is due to be considered at the People & Culture Committee in December 25 and an update will be provided at the next Audit Committee. **11.09.25** An update was provided to the People and Culture Committee in August 2025, this is due to go back to the People and Culture Committee in December 2025 once the new Executive Medical Director has commenced in post and will then come back to the Audit Committee.
6	**AC25/70.1**	08.05.25	**Final Internal Audit Reports (Clinical Audit Report)** Interim Executive Medical Director to take the Clinical Audit Plan to the QSE Committee and bring this back to the Committee in due course to approve the Clinical Audit Plan and receive assurance on progress.	~~Sree Andole~~ Clara Day	October 25	**Remain Open** **16.12.25** Agenda item AC25.160 **28.10.25** The Clinical Improvement Plan was deferred from the October to the December meeting and is included on the agenda for the December Audit Committee. **11.09.25** The Clinical Audit

						Improvement Plan is included on the agenda for the October 25 meeting, propose this action is closed. **07.07.25** The Clinical Audit Plan was received by the QSE Committee in July, further work is required and this will be received by the Audit Committee in October 25.
7	**AC25/32.1**	04.03.25	**Information Governance and Records Management Position** The Executive Committee to take some time to consider the matter, identify best practice, clarify that the risk is logged and bring the item back to the Committee.	Pam Wenger Dylan Roberts	~~Oct 25~~ Revised timescale Feb 26	**Remain Open** **11.09.25** The PFIG Committee received an update on Information Governance and Records Management at their meeting on 26.08.25 - please see link below to the paper and note item PF25.74 Information Governance: PFIG Agenda Bundle 26.08.25 This requires further discussion with the DDaT Team. **29.07.25** A session on records management to take place with the Executive Committee and this will be included on the agenda for a more substantive item at a future meeting. **19.03.25** Dylan Roberts to discuss with Carol Shillabeer and agree how the corporate records management function will be resourced. A paper will be presented to the Executive Committee and come back to a future meeting of the Audit Committee.

8	**AC24/151.1**	05.11.24	**Centre for Mental Health and Society (CfMHaS)** (Title changed from Response to Freedom of Information Request) A full evaluation report to be presented at the next Audit Committee.	Pam Wenger Russell Caldicott	~~March 25~~ ~~May 25~~ Revised timescale Feb 26	**Remain Open** **27.11.25** Audit in progress update to be provided by Head of Internal Audit. **11.09.25** An update has been provided in the Corporate Governance Report. The procurement of an independent reviewer has been completed and the evaluation report is anticipated to be available for the next meeting in December 2025. **27.07.25** An extended deadline of 10 July 2025 was provided and the Health Board has received two expressions of interest. The Corporate Governance Directorate will now progress this in partnership with the Procurement Team with work estimated to commence during August 2025 with an update to Audit Committee planned for October 2025. **09.05.25** An independent reviewer has been sought on the procurement portal (since 14.03.25). Currently awaiting expressions of interest to complete the work. A report is due to go to the Committee in June 25 dependant on securing an independent reviewer. **04.03.25** In relation to the Centre for Mental Health it has been agreed to

						commission a review and this will come back to Committee. **03.02.25** ToR have now been drafted and awaiting final review before procurement in February 2025. A full evaluation report is due to be presented to the Committee in April 25 (subject to procurement) **08.01.25** An evaluation of the CfMHaS Agreement will be commissioned and the final report will be brought to the Committee once received. The terms of reference for the review are currently being finalised in order that procurement for the review can be commissioned.
9	**AC25/136.3**	21.10.25	**Statutory Compliance Report** Chief Operating Officer to refer to Audit Wales recommendation 1364 in relation to Urgent and Emergency Care when presenting to the Committee in December 2025.	Tehmeena Ajmal	Dec 25	**Remain Open / Propose to close** To consider as part of agenda item AC25.158 Update on Outstanding Audit Recommendations and to consider closure if the Committee is content.
10	**AC25/142.1**	21.10.25	**External Audit Progress Report** Chief Operating Officer to join the December meeting to provide an update on the Internal Audit recommendations, the thematic work on Urgent and Emergency Care and the recent Planned Care and Unscheduled Care reports.	Tehmeena Ajmal	Dec 25	**Remain Open / Propose to close** Agenda item AC25.158 Update on Outstanding Audit Recommendations - consider closure if the Committee is content.
ACTIONS PROPOSED FOR CLOSURE						

11	**AC25/69.2**	08.05.25	**Internal Audit Progress Report** Executive Director of Finance and Head of Internal Audit to meet and discuss the Scheme of Reservation and Delegation further to align the process and gain clarity on the narrative.	Russell Caldicott Dave Harries	~~August 25~~ Revised timescale Dec 25	**Propose to close** **27.11.25** A paper was provided to the Board on 27.11.25 and discussed in private session (Agenda item 25.230) **14.10.25** The Director of Performance and Commissioning has responsibility for this element, as this role is currently vacant the Director of Finance will include a report on contracts within the Health Board Finance Report and at this point the action is expected to be closed. **19.08.25** It was agreed during the meeting that this action should remain open as the delegation to Officers has not yet taken place. It was noted by the Head of Internal Audit that for the Health Board to be compliant in 2025/26 there is a need to go through the process to confirm the formal delegation for sign off of healthcare agreements. **08.07.25** Discussions have concluded, the report is compliant with SFIs which would have satisfied the requirement to approve contracts however the Executive Director of Finance was on leave and the report was not taken by Committee. This will be corrected moving forward. The report as produced, requires

						presentation to the Committee and subsequent recommendations for approval to Health Board to ensure Compliance and delegation to Officers for 2025/26.
12	**AC24.60.1.10**	07.05.24	**Internal Audit Progress Report** Limited Assurances relating to the Lessons Learnt Report dated July 2023 and the follow up progress to date. Chair / Director of Corporate Governance to raise in the Chairs Advisory Group as an emerging topic.	Urtha Felda Pam Wenger Philippa Peake-Jones	~~June 25~~ Revised timescale Dec 25	**Propose to close** **27.11.25** this item was raised at the Chairs Advisory Group **06.10.25** This item has been included on the agenda for the next Chairs Advisory Group for discussion. **29.07.25** Verbal update by Vice Chair to be provided during the meeting. **10.04.25** This has been included on the agenda for the next Chairs Advisory Group which is due to take place on 24.04.25. **08.01.25** The Head of Corporate Affairs has included this on the agenda for the next Chairs Advisory Group for discussion which is due to take place on 26.02.25. This meeting has subsequently been stood down and this item will roll over to the next meeting. **08.10.24** The recommendations included in the Lessons Learnt Audit Report have been shared with the Chair, this will be discussed at the Chairs Advisory Group in October and the Chair will provide a verbal

						update at the Audit Committee in November. **12.09.24** This will be discussed at the next Committee Chair's Meeting. **02.09.24** Update to be provided during the meeting. **18.07.24** To be raised at the next meeting in August 2024 as part of feedback from the Audit Committee Chair.
13	**AC25/141.1**	21.10.25	**Internal Audit Progress Report** Committee Chair, Vice Chair and Head of Internal Audit to meet with the Chief Executive to raise concerns around Internal Audit report turnaround times and the lack of sufficient evidence being provided.	Paul Lambert Urtha Felda Dave Harries	Feb 26	**Propose to close** **13.11.25** Urtha Felda advised that meetings had taken place with the Chief Executive, and also Internal Audit, in which a new approach to managing Executive Directors' standard of evidence had been agreed. The Director of Corporate Governance referenced this at the Committee development session on 4.11.25 and also confirmed in the Audit Committee Chairs Report to the Board
14	**AC25/137.1**	21.10.25	**Revised Policy Management Process** Final version of the Policy Management Process to be presented to the Committee in in December 2025 for onward approval by the Board in January 2026.	Pam Wenger Glesni Driver	Dec 25	**Propose to close** 4.12.25 Refers to agenda item AC25.162 Policy Management Process

Closed Actions (as agreed at meeting on 21.10.25)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
15	**AC25/111.1**	19.08.25	**Accountability Framework (Review of the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions)** Further work is required in relation to the levels of delegation before this goes to the Board in September 2025.	Pam Wenger	Oct 25	**11.09.25** Discussions have taken place with the Director of Corporate Governance and Head of Internal Audit to agree the levels of delegation and this is being presented to the Board in September 2025.
16	**AC25/115.1**	19.08.25	**Internal Audit Progress Report: Orthopaedic Surgical Hub Llandudno Hospital** A briefing on Llandudno Hospital to be circulated outside of the meeting with confirmation of progress to date	Russell Caldicott	Oct 25	**14.10.25** An update report from the Executive Director of Finance has been shared with members and circulated in advance of the meeting.
17	**AC25/115.2**	19.08.25	**Internal Audit Progress Report: Performance Management Framework and Reporting** The Audit Committee Chair to write to the Chief Executive to highlight concerns regarding the lack of progress in relation to Performance and the Contracted Patient Services Review.	Urtha Felda Pam Wenger	Oct 25	**09.10.25** Urtha Felda sent a letter to Carol Shillabeer raising the concerns discussed.
18	**AC25/116.1**	19.08.25	**External Audit Progress Report** Director of Corporate Governance to share the Structured Assessment brief with the Committee.	Pam Wenger	Oct 25	**11.09.25** The Structured Assessment brief has been circulated to Board members and interviews with External Audit have been arranged.
19	**AC25/117.1**	19.08.25	**Management Response to Audit**	Russell Caldicott	Dec 25	**11.09.25** The Planned Care Report

			ales Planned Care Report Progress in relation to the Audit Wales Planned Care Report to be discussed in further detail by the PFIG and QSE Committees and reported back to the Audit Committee.	Tehmeena Ajmal		has been presented to both the PFIG and QSE Committee and an update is included on the agenda for the October meeting. Monitoring of progress will now form part of regular reporting and will be included in the compliance report.
20	**AC25/64.1**	08.05.25	**Corporate Risk Register and Board Assurance Framework** A paper to be presented to the Committee setting out the arrangements for managing the risks relating to External Recommendations and Response plans.	Pam Wenger Nesta Collingridge	Oct 25	**09.09.25** A session with the Board has taken place and an item has been included on the agenda for the meeting in October 25 focussed on the review of the risk appetite and management framework. **07.07.25** Risk Appetite Session with the Board is scheduled for August 25. The Corporate Governance Directorate and the Executive Team have reviewed the risk relating to this and it is being de-escalated from the Corporate Risk Register due to plans in place to monitor external recommendations from various Committees. The Committee is asked to confirm if any further assurances are required at this stage.
21	**AC25/64.2**	08.05.25	**Corporate Risk Register and Board Assurance Framework** A deep dive to take place in relation to risks CRR21-22 Orthodontic Services and CRR24-25 Dermatology and Plastic Surgery Services.	Pam Wenger Nesta Collingridge	Oct 25	**06.10.25** A report and presentation on Challenged Services went to the QSE Committee in September 2025 and this will continue to be monitored at each QSE Committee. **07.07.25** This has been scheduled for

						the QSE Committee in September 25 and will be reported back to the Audit Committee.
22	**AC25/67.2**	08.05.25	**Welsh Health Circulars and Ministerial Directions** Update on incomplete WHCs requiring immediate action at the next or a future meeting.	Pam Wenger Glesni Driver	Dec 25	**11.09.25** Reporting against WHCs will be presented on a bi-annual basis and this update will form part of the Statutory Compliance Report being presented to the Committee in December 25. **01.07.25** Work is taking place and this will be presented to a future meeting of the Committee. WHCs now form part of the Compliance Report which is included on the agenda for the August 25 meeting.
23	**AC25/69.1**	08.05.25	**Internal Audit Progress Report** Director of Performance and Commissioning to report on the progress of the follow up on the Contracted Patient Services – Quality and Safety arrangements at the August meeting.	Stephen Powell	August 25	**11.09.25** This action has been superseded by action AC25/109.1 and propose this action is closed. **19.08.25** It was agreed during the meeting that this action should remain open as this was not reported to the meeting in August 25. **29.07.25** This is included on the agenda for the August 25 meeting.
24	**AC25/04.1**	16.01.25	**Matters Arising and Action Log (Trusted Assessor)** Board Development Session focussing on the role of the Trusted Assessor to be arranged.	Pam Wenger	~~March 25~~ Revised timescale October 25	**11.09.25** Discussion is taking place with the Health Board Chair around how best to deliver briefing sessions. Plans are in place to hold a session in November 25 on the role of the Trusted Assessor for those IMs that require this session.

						29.07.25 This is being discussed with the Chief Operating Officer to arrange a session for Independent Members. **10.02.25** The session will be added to the Board Development Programme and a suitable date arranged for 2025/26. This will not be before March 25 but will be planned before September 2025 as it would be helpful for the new COO to co-ordinate this session.
25	**AC24/124.3**	12.09.24	**Update on Health Board Policies and Written Control Documents** It was agreed that further work is required to put mechanisms in place and establish a process on the review of policies and procedures and an update will be provided in the future.	Pam Wenger Glesni Driver	~~Nov 24~~ ~~Jan 25~~ Revised timescale October 25	**11.09.25** The update on the new process for policies has been included on the agenda go the meeting in October 2025. **07.07.25** A revised policy is being developed and will be presented to the Committee in October 25. **01.07.25** Work on the new process is ongoing with the approval routes for these documents still requiring further work to align to operational and strategic meetings / Committees. **12.03.25** An update on progress around a revised policy process will be provided to the June 25 meeting. **03.02.25** Work on the Health Board policy review and approval processes has commenced, which will include a full consultation process, as well as a refresh of the 'Policy on Policies'. An

						update will be provided at the meeting in June 25. **10.12.24** A paper has been included on the agenda for the January meeting. Further work is required on policies once progress has been made against the current policies. **24.10.24** The immediate focus is reviewing the work in terms of the governance and overdue policies. There is opportunity to review the current processes going forward but given the focus on dealing with overdue policies this will be the immediate priority. This has been included on the forward workplan in terms of the long term review of the processes.
26	**AC24/121.2**	12.09.24	**Speak Up Safely** Future update to consider the compliance against the policy/protocol and particularly in the context of raising concerns and Whistleblowing arrangements.	Internal Audit Jason Brannan Tracey Eccles Rebecca Testa ~~Gareth Evans~~	~~Nov 24~~ ~~Jan 25~~ ~~March 25~~ ~~May 25~~ Revised timescale October 25	**09.09.25** Dave Harries confirmed that an Internal Audit review on Speaking up Safely is currently being agreed and will commence shortly therefore suggested this action can now be closed form an Internal Audit perspective. This was agreed with the Workforce Team. **04.07.25** Process review underway to align current SUS process to All Wales SUS Framework. This is due for completion by end of Q2. **17.04.25** An SBAR has been

						submitted via Jason Brannan for a review of the referral process of submitting a concern and aligning the reporting data to allow comparison against other Health Boards / Trusts. **04.03.25** The Audit Committee approved the Internal Audit Plan for 2025/26 which includes Speaking up Safely as review reference 25. It is planned for Q4 but Internal Audit have agreed with management's request to bring the review forward earlier in the year. **19.02.25** An SBAR is being prepared to share with the Executive Team to gain approval to begin a process of review of the SuS framework and arrangements to include reviewing compliance and factors related to this included in the action tracker. Part of this review will include involving other stakeholders in the process to identify what the SuS Team currently provide from the perspective of a number of interested parties e.g. Trade Unions, Board Champions, Staff Networks, People Services, Information Governance, and if appropriate, Internal Audit. This will provide a more comprehensive review of the framework and approach and offer a

						greater level of assurance too. Speaking Up Safety is also included in the draft BCU Internal Audit Plan for 2025-26, which is being presented for approval at the March 25 meeting. **28.10.24** Speaking Up Safely as a mechanism and route to raising concerns was included in the Raising Concerns policy and process when first launched in July 2021, and again reviewed when the Raising Concerns policy and process was updated. The SUS team will engage in further work to explore any specific additions or adaptions to current practice that may be needed in relation to Public Disclosure (Whistleblowing) **16.09.24** Internal Audit will consider Speak Up Safely as a key risk area for the 2025/26 internal audit planning cycle following presentation of the report by Officers and observations made by Committee Members.

Audit Committee

Chief Operating Officer (COO) update presentation on Open Audit Recommendations

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Tuesday 16th December 2025

Limited Audit Reports presented:

Audit Body	Report Title / Objective(s)	Year	Assurance Level	Number of actions in response to findings	Number of actions implemented / complete	Total number of actions open
Internal Audit	**Waiting List Initiative (WLI) payments – Integrated Health Community (IHC) Centre** There is a current WLI procedure in place that is available for all staff that aligns with the Amendment to the National Consultant Contract in Wales. WLI activity is only commissioned and agreed to be undertaken in uncontracted time	2025	Limited	5	0	5
Internal Audit	**Effective Governance – Cancer Services** There are appropriate financial governance arrangements in place to manage budgets. The service is progressing and monitoring tier 2/3 clinical audits & contributing to tier 1 audits. Complaints, concerns, incidents & staff concerns are investigated, reviewed, and responded to in a timely manner and learning shared.	2025	Limited	6	5	1
Internal Audit	**Effective Governance – IHC Community – East (EIHC)** There is appropriate governance and reporting structure in place There are appropriate financial governance arrangements to manage the financial position. The service is progressing and monitoring tier 2/3 clinical audits & contributing to tier 1 audits. Complaints, concerns, incidents & staff concerns are investigated, reviewed, and responded to in a timely manner and learning shared Risk management processes are embedded throughout the IHC	2025	Limited	6	0	6

Waiting List Initiative payments – Central IHC

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Updated online form piloted the use of additional, and mandatory, questions to document that i) WLI activity complies with the National Consultant Contract (NCC) in Wales requirements and, ii) record whether the WLI activity will be undertaken in uncontracted time. These questions on the e-form are mandatory for completion before it can be submitted. Draft procedure being developed and progressing through the Health Board policy approval process including consultation process prior to final approval and implementation. A Job Planning protocol has been co-developed by the Office of the Medical Director with the chair of the Joint Local Negotiating Committee (JLNC) and local British Medical Association (BMA) representation. The draft form was agreed at JLNC and the October Medical Workforce Group who will own progression of job planning. The final agreed protocol will be signed off by end Dec 2025.	Job planning across BCUHB will be a work in progress over the next 12-18 months; service needs will be more clearly defined after Foundations for the Future programme	The new electronic form captures confirmation that WLI activity is being performed in uncontracted time. This will be audited by operational and medical leadership teams.	Evidence provided of amended forms to confirm process established to confirm compliance with the NCC requirements and reporting of WLI activity. Proposal to close related actions. **January 2026** In the meantime, a training needs analysis is underway to support roll out; job planning can of course continue as the protocol simply outlines what is already underway and has further clarity surrounding appeals processes. A revised trajectory has been proposed for 90% sign off by the end of Q1 26/27.

Effective Governance – Cancer Services

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION / DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Monthly Performance, Finance and Information Governance (PFIG) meetings continue with multi-professional oversight of spend and review of any additional funding requests. Weekly establishment control meeting with Divisional General Manager (DGM), Head of Nursing (HoN), finance and people services to review all roles at Divisional Management Team (DMT) stage – only roles that are funded and considered essential are approved All budget holders meet regularly with finance partners to ensure budgets are managed The number of incidents since March has continued to decrease and significantly to 50 open incidents in October of which 34 were overdue. This is due to an agreed action of discussing and encouraging the investigating and closing of incidents in a timely manner at the daily patient safety huddle.	N/A	Close partnership with Medicines Management for drug spend and potential savings. Systemic Anti-Cancer Therapy (SACT) drug production has been restricted in the cancer pharmacy units for safety reasons resulting in increased outsourcing of production	The grip and control of expenditure is evident through Minutes / agenda of the Senior Leadership Team (SLT) through to PFIG to operational leaders who are accountable for respective cost centres. January 2026 Patient Safety Huddle, weekly e-mail reminders to incident handlers by the Patient Safety team and by further. Samples of data to be supplied to support closure through executive team and audit committee.

Effective Governance – Integrated Health Community – East

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION / DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Governance Terms of Reference (ToRs) are in place for each meeting, IHC Director confirmed as Chair. In the absence of EIHC Director a deputy Chair is identified from SLT members.	N/A	ToRs reviewed annually including membership	Updated ToRs and action notes provided of SLT meeting where Chair reports from all IHC committees / groups as evidence and propose to close this action
Accountability Letters 64 accountability agreements have been signed, 14 are outstanding of which 3 have a valid reason noted. Work ongoing to progress outstanding agreements for signing		Meetings arranged to discuss concerns / queries for budget holders awaiting sign off of agreement. Escalation process to COO where needed.	January 2026
Delivering Financial balance Monthly Cash Releasing Efficiency Savings (CRES) meetings held with each service area to review budgetary position and extraordinary meetings to discuss further measures		Extra meetings with OLT to discuss / escalate areas of concern.	January 2026

Effective Governance – Integrated Health Community – East

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION / DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Open / Closed incidents IHC improvement trajectory in place for a reduction of incidents open >30 days. As at 3rd November there is a total of 453 (54%) open incidents of which 394 (47%) are open > 30 days. The trajectory is currently being achieved with actions to improve by disaggregating to directorates		Incidents are monitored in weekly East Integrated Concerns Operation Group (EICOG) meeting with a trajectory by directorate to report against open /closed / length of day	Ongoing review and monitoring of trajectory agreed and being monitored to deliver 40% reduction in open incidents by end March 2026 reviewed at SLT meetings
Review of Risks Risks are discussed monthly at the IHC Risk Management meeting		Ongoing monthly reviews to ensure mitigating actions progressed and risk register updated	Notes of risk management meetings submitted as evidence of discussions. Risk Register to be submitted also.

Open Audit Wales Recommendations

ID	Report Title / Recommendation title	Key Finding	Management response	Update
1364	Urgent & Emergency Care: Flow out of hospital – NW Region / Addressing key gaps in capacity	R10: The Health Board and local authorities need to work together to develop joint solutions to address key gaps in service capacity, in particular, domiciliary care and reablement services which would enable timelier discharge of patients to their own home	**Sub-regional:** Utilise Further Faster Funding and action planning In Central, Discharge to Recover & Assess (D2RA) team at the front door working as Trusted Assessors to address the gaps in assessment capacity working together with local authorities to support reablement provision ongoing work to support more timely discharge required for packages of care with agreed Trusted assessment pathways Central Area Integrated Services Board considers the development of joint solutions to address key gaps in service capacity e.g the Denbigh Health and Social Care Programme. The Health Board have developed the Tuag Adref service in the West to provide for a reablement service and domiciliary care is now jointly commissioned by Local Authorities and the Health Board.	The region now has in excess of 90 contracts signed with Domiciliary Care Providers as part of the North Wales Dom Care Agreement which went live on 1st April 2025. The agreement includes lots for complex adults and children. In addition the 6 Local Authorities have prioritised Transformation funding to increase reablement and Dom Care capacity, including additional support of Occupational Therapists to ensure right-sizing of care packages.

Corporate Risks / Board Assurance Risks

RISK TITLE	OPEN DATE	TARGET DATE	RISK SCORE	CHANGE IN RISK SCORE	KEY ACTIONS TO REDUCE THIS RISK SCORE	BARRIERS TO IMPLEMENTATION / DELIVERY	RISK APPETITE
CRR25-01 Timely patient access to safe and effective care	21/8/25	30/6/27	20	N/A	All risks relating to delays and safe and effective care have been amalgamated into one overarching corporate risk with respective actions set out with timelines	As well as current mitigations / controls in place, additional necessary controls have been identified together with action plans to address any mitigations	Not in tolerance
BAF24-07 Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	20/10/24	31/3/25	20	Increased from 16 to 20 following review at Exec Committee	A number of controls are identified within the plans to manage the risk and reduce the likelihood / impact of the threat, this is including against any gaps in controls and are set out in the assurance document	As well as current mitigations / controls in place, additional necessary controls have been identified together with action plans to address any mitigations	Not in tolerance

Teitl adroddiad: ***Report title:***	Consultant Job Planning
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025
Crynodeb Gweithredol: ***Executive Summary:***	This paper is to update the Audit Committee on the actions associated with the follow-up Internal Audit of August 2025 pertaining to the roll out of Senior Doctor job planning across BCUHB Senior doctor job planning is vital to ensure that there is clarity on job responsibilities both for the individual and the service. It is a collaborative approach which defines service needs in addition to the development needs and skill sets of the clinicians. Welsh Government has targeted a 90% compliance on consultant job planning by Sept 2025. This target has not been met by BCUHB. Currently 46% have a signed off job plan with a further 13% awaiting sign off. There is considerable variability across areas of the HB: East IHC has 69% with a further 7% awaiting sign off whereas Central IHC has only 11% signed off with 15% awaiting sign off. The response to internal audit requirements within this paper summarises next steps for BCUHB to progress wider job planning. A Job Planning protocol has now been co-developed by the Office of the Medical Director with the chair of the Joint Local Negotiating Committee (JLNC) and local BMA representation. This was agreed in draft form at the most recent JLNC meeting and the October Medical Workforce Group who will own progression of job planning. The final agreed protocol will be signed off by the end of Dec 2025. In the meantime, a training needs analysis is underway to support roll out; job planning can of course continue as the protocol simply outlines what is already underway and has further clarity surrounding appeals processes. A revised trajectory has been proposed for 90% sign off by the end of Q1 26/27. Job planning across BCUHB will be a work in progress over the next 12-18 months; service needs can be more clearly defined after changes associated with the Foundations for the Future programme. This paper was considered at the People and Culture Committee on 4.12.25

<table>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to note the revised plan for Senior Doctor job Planning.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Dr Clara Day Executive Medical Director</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Dr Clara Day Executive Medical Director</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☒</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☐</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">This report aligns with all the strategic objectives;

Strategic Goal 1: Building an effective Organisation

Strategic Goal 2: Developing strategy and long-lasting change

Strategic Goal 3: Creating compassionate culture, leadership and engagement</td></tr>
</table>

	Strategic Goal 4: Improving quality, outcomes and experience **Strategic Goal 5**: Establishing an effective environment for Learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Non applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Non applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	This work links to the following Strategic Risk; **BAF24-01: Not Fully Building an Effective and Accountable Organisation** Ineffectively delivering interconnected governance, operational, performance, and legislative challenges that could impede the Health Board's ability to develop a high-functioning, accountable, and cohesive organisation. **BAF24-03: Not Achieving Long Term Financial Sustainability** **BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability** A risk that the Health Board may inadequately foster a compassionate culture and strong leadership, resulting in disengaged staff, low morale, and high turnover. **BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes** Risk of ineffectively delivering consistent high quality of patient care across the HB resulting in incidents of avoidable harm and poor clinical unmet patient needs, regulatory non-compliance, and reputational harm. **BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm,**

	Poor Delivery of Performance Targets and Reputational Risk Risk of ineffectively delivering timely access to care resulting in potential clinical harm, poor delivery of performance targets and reputational risk **BAF24-08: Not Implementing Evidenced Based Improvement and Innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Nil. Will be within current medical spend.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	More productive senior doctor workforce
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Reviewed in Joint LNC meeting and Medical Workforce Group October 2025. Verbal update to Audit Committee 21st October 2025
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Listed Above
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Continued implementation overseen by Medical Workforce Group.	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Appendix 1: Follow-up: Consultant Job Planning Final Internal Audit Report: 2025/26	

Follow-up: Consultant Job Planning

Final Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Contents

Review Reference	BCU-2526-27
Fieldwork	August-September 2025
Executive Sign Off	October 2025
Audit Committee	October 2025
Executive Lead	Clara Day, Executive Medical Director Georgina Roberts, Interim Executive Director of People Services and Organisational Development (POD)
Audit Team	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall objective of this audit is to provide the Health Board with assurance regarding the implementation of the agreed management actions from the *Consultant Job Planning (BCU-2425-20)* review, rated unsatisfactory, that was reported as part of our 2024/25 work programme. The scope of this follow-up review does not aim to provide assurance against the full scope and objectives of the original review.

The report identified eleven issues for management consideration; all eight high-risk actions had agreed implementation dates no later than 31 May 2025; three medium risk issues (Issue 2, 4 and 9) have agreed implementation dates of 30 September 2025. As the high-risk issues are now past the agreed implementation date, we agreed with management to follow these up; the three medium-risk issues will be followed up as part of the routine follow up process undertaken in conjunction with the Corporate Governance Directorate.

Overview

The table below illustrates the status of the agreed actions; we found only one issue can be fully closed with another partially implemented.

	High	Medium	Low	**Total**
Closed	1	-	-	**1**
Partially Implemented	1	-	-	**1**
Outstanding	6	-	-	**6**
Total	**8**	**-**	**-**	**8**

Some progress has been made - the Health Board's strategic objectives have been refreshed and updated within the EJob plan system; and we were able to evidence inclusion of these within our sample of job plans reviewed. We found localised good practice in both Women's Services and IHC West where job plan matters formed part of meeting agendas.

However, the remaining high-risk issues have yet to be implemented despite these being agreed by management within realistic timelines.

- The Health Board's Job Planning Compliance is currently at 43% (1st September 2025); it is highly unlikely to meet the 90% target, set by the Welsh Government[1] which states *'90% of all Consultants have an agreed job plan in place at all times by 30 September 2025.'* We note this has been an issue on the Medical Workforce Group (MWG) agenda since the 8 July 2025 meeting but can find no other routine reporting on this specific target.
- The Health Board has not published the draft policy/procedure since our review as it awaited an all-Wales guide, which has yet to materialise. The Health Board policy/procedure is critical to ensure internal control in job planning is consistent across the Health Board, and to ensure compliance with the nationally agreed contract.
- There has been no formal review of first and second sign-off within the EJob Plan system, consequently it remains unclear whether the correct officers are reviewing and approving job plans. Further, test and generic details remain in the 'live' system, exposing the system to risk of inaccurate reporting.

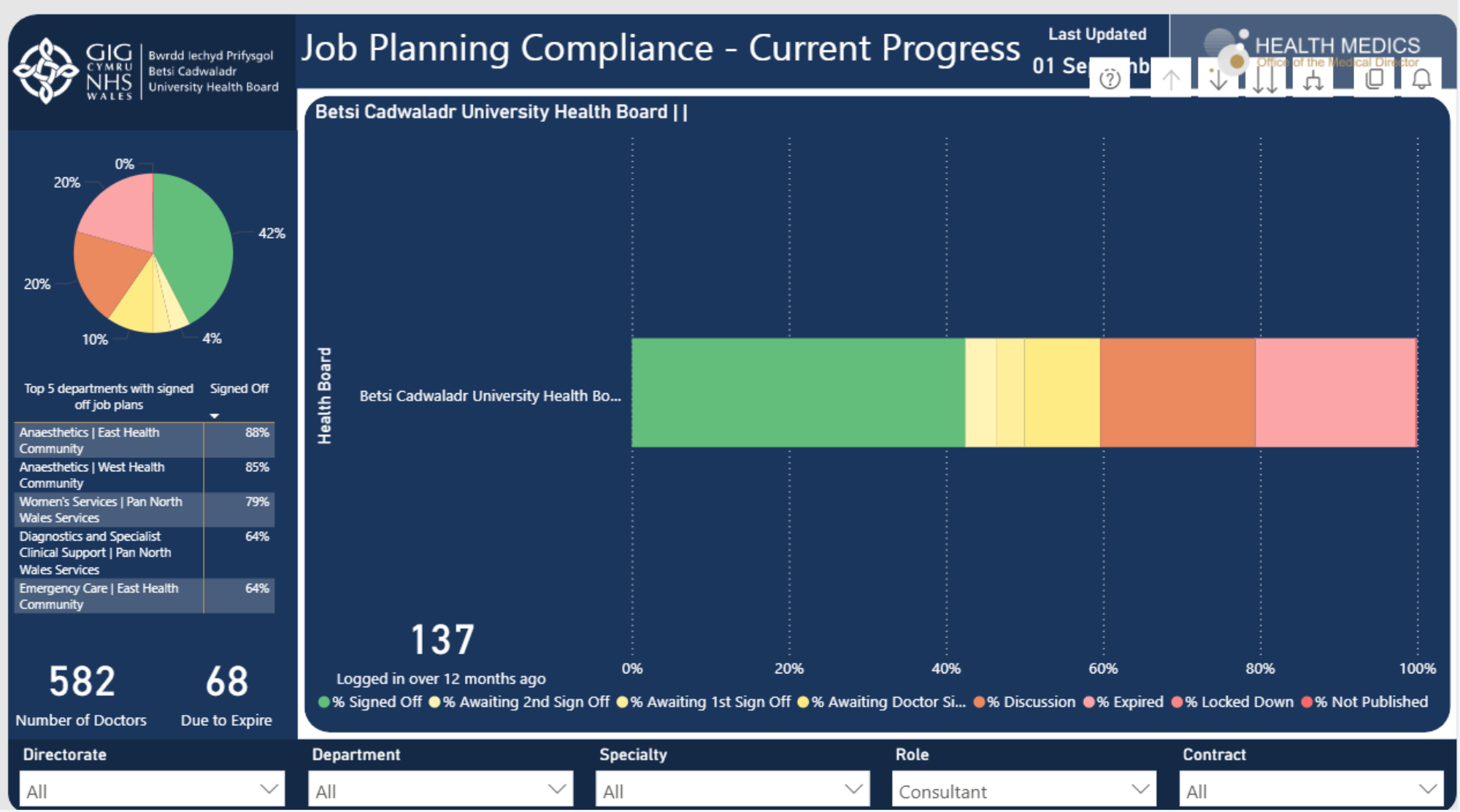
[1] Welsh Government Remit Letter to the NHS Wales Executive 2025-26 – Workforce Productivity reference 6.4 (page 22) performanceandimprovement.nhs.wales/about-us/key-documents/annual-plans-and-remit-letters/welsh-governement-remit-letter-to-the-nhs-executive-2025-26/

- No directorate or specialty service objectives have been recorded or documented, which may affect effective service transformation and ongoing improvement – this represents significant oversight by management and should be embedded in every job plan review.
- Reporting on medical and dental job plan performance is inadequate; whilst recognising the MWG has a specific agenda item, and hyperlinks to the dashboard are shared widely by the Office of the Medical Director's Job Planning team, there is no evident reporting to the Health Board's People and Culture Committee or local People & Culture meeting via the respective People Operations Report.

We received a reply to the request for information from Central, East and West IHCs and Women's Services. Again, we must report that Mental Health and Learning Disabilities, Cancer Services and North Wales Managed Clinical Services did not reply to our request for evidence, required by Standing Financial Instruction 3.2.2.

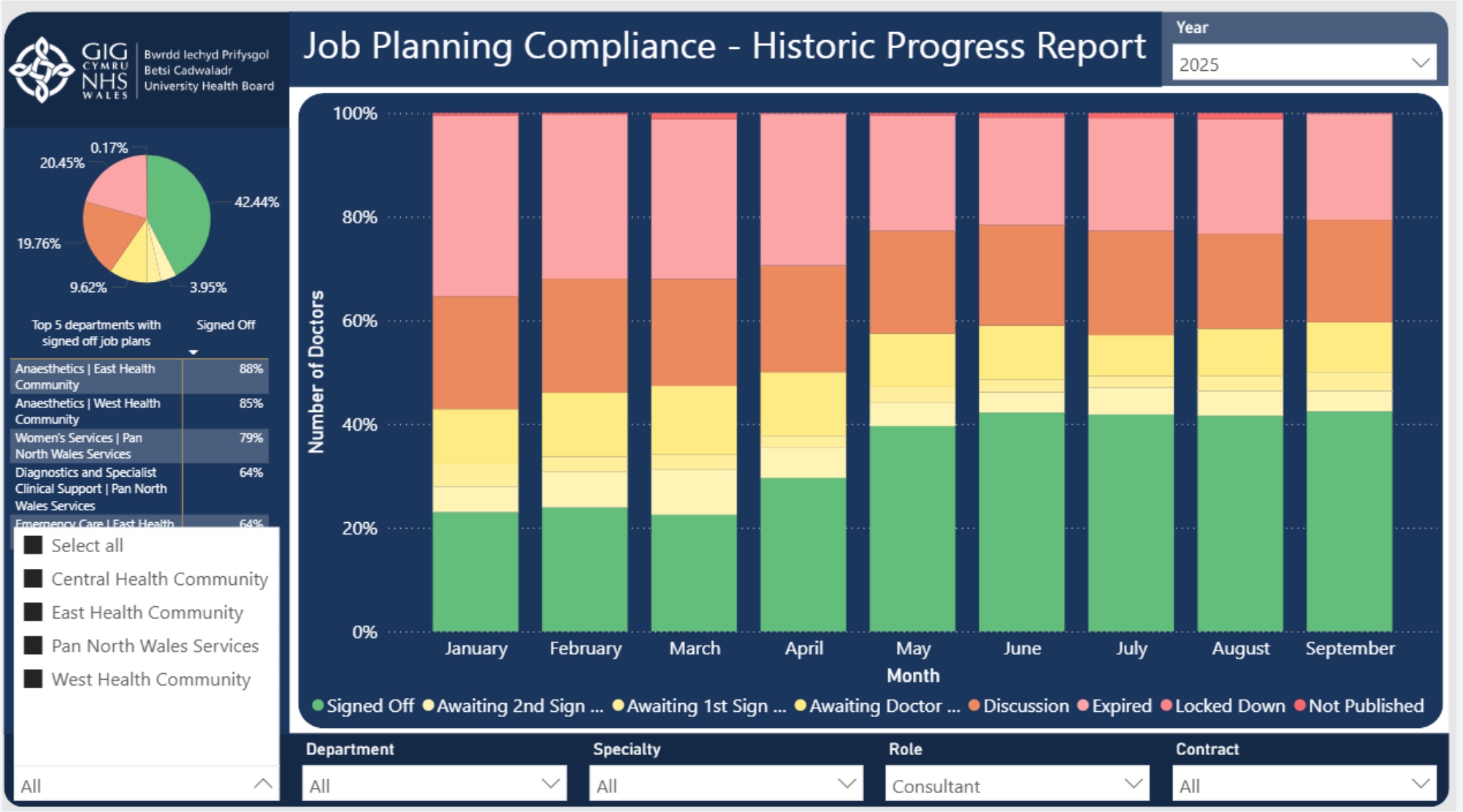
Health Board Consultant Job Plan data - At a Glance

Image 1: Health Board Job Plan dashboard compliance 1 September 2025 – Consultant Role



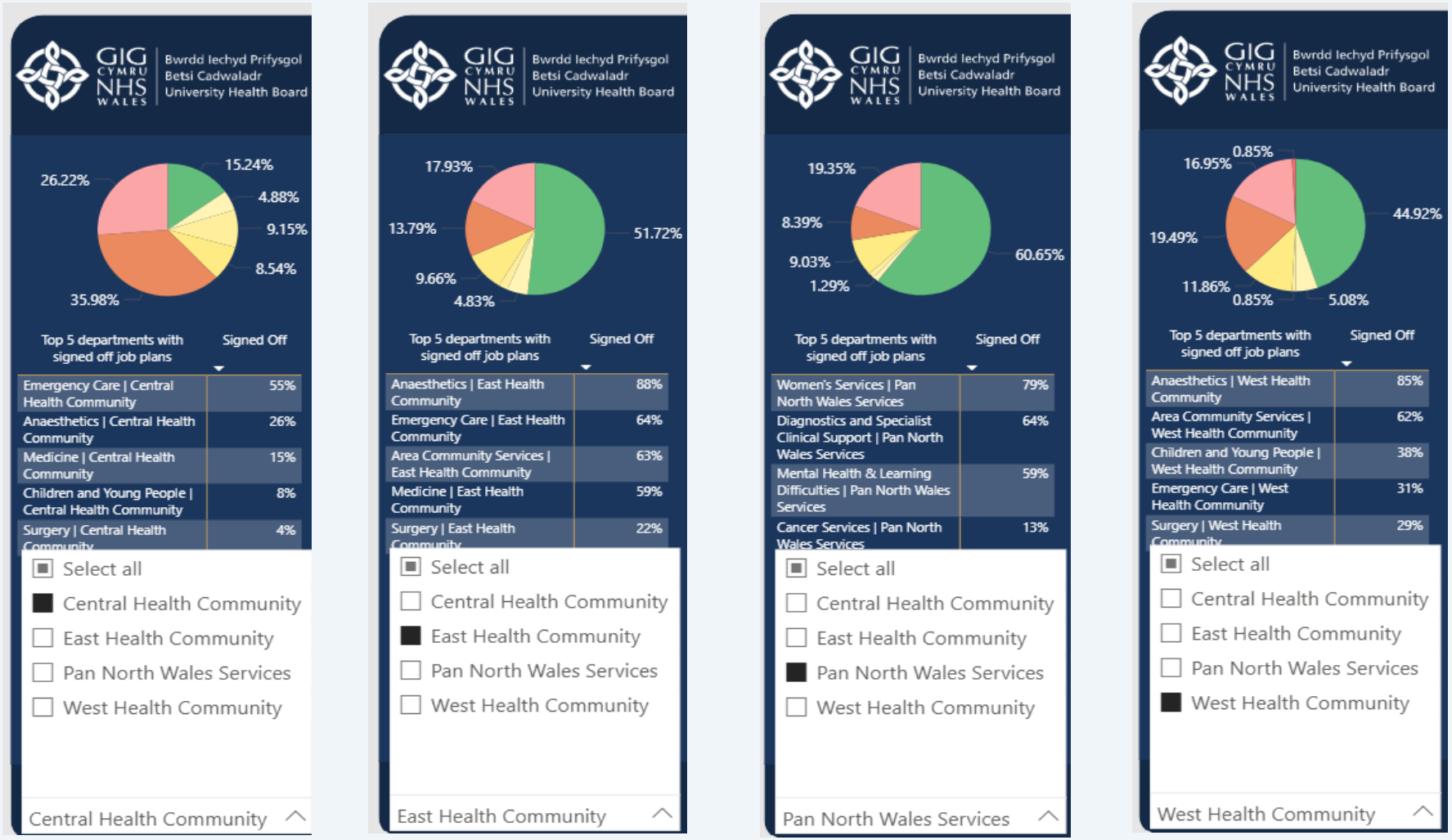
Source: Health Board Job Plan Progress Dashboard 1 September 2025 16:17 Job Planning Compliance - Current Progress - Power BI

Image 2: Health Board Job Plan dashboard compliance 1 January to 1 September 2025 – Consultant Role in total and by Service



Source: Health Board Job Plan Progress Dashboard 1 September 2025 16:22 [Job Planning Compliance - Historic Progress - Power BI]

Image 3: Health Board Job Plan dashboard compliance 1 January to 1 September 2025 – Consultant Role by Service



Source: Health Board Job Plan Progress Dashboard 1 September 2025 16:22 Job Planning Compliance - Historic Progress - Power BI

Status of Previously Agreed Recommendation

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.				
1.	**Health Board Policy** The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011. Limited training is provided to all individuals involved in the job plan process.	Interim Medical Director 31 May 2025	**High**	**Current status – Not implemented** **Finding** The Health Board does not have an agreed Policy/Standard Operating Procedure in place to support management, and consultants fulfil expected compliance with the nationally agreed Consultant Contract. This remains a significant gap in internal control. We are advised that the Health Board has not progressed with its own draft policy/procedure as it waited for nationally developed best practice guidance which has not materialised. With no policy or standard operating procedure in place, we recognise the decision not to develop a Health Board wide training needs analysis. We have seen evidence where the Job Planning Specialist undertakes ad-hoc training and note this as good practice. **Revised Action, Responsibility and Timescale** The final draft of the BCU job planning policy (JPP) (co-authored with LNC / BMA) is to be discussed by Executive Medical Director at JLNC meeting on 14 October 2025. It is anticipated that final approval of the JPP will be secured by December 2025. However, this is a re-iteration of current principles and processes and thus implementation can continue as this goes through final sign off. A training needs analysis has identified 3 core staff groups, with trajectory for completion of training: 1. All medical staff in leadership position with operational responsibility will require training against the JPP. Training

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
				to be completed for all within 2 months of JPP approval. Training will be delivered as a series of roadshows, which are planned to be delivered jointly by senior medical leaders and LNC colleagues. 2. Operational staff who will be supporting team and individual job plan meetings. These staff will require both training re JPP and the use of Allocate system. Completion of training re JPP within 2 months of sign off. Allocate training 6 months from date of submission of this paper i.e., March 2026 3. Medical staff who are required to have annual job plan in place. Training for this staff group will be managed via 2 processes (a) alongside the medical leadership team, anticipated compliance with training will be 60% within 2 months of JPP approval (b) linked to the date of their next job plan for those who have not attended initial 'roadshow' training events. Compliance of above 95% training would be achieved within 1 year of JPP approval dependant on distribution of individual job planning meeting dates. The JPP starts to detail core SPA activity, and possible tariff for additional SPA over core. Expectation is that evidence is provided at job plans for all SPA (and DCC) to secure the SPA payment. Standard of evidence will need to be a focus of training for all staff Compliance is tracked locally by Medical Directors / Clinical Directors and Directorate General Managers (or equivalent). Rates will be monitored via local People and Culture and local workforce groups. At Health Board level compliance will be reported via Medical Workforce Group, highlighting any departments of concern. **Executive Medical Director** **31 May 2026**
3.	**EJob Plan First and second sign-off**	Interim Medical	**High**	**Current status – Not implemented**

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	Through a review of first and second sign off details in the EJob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system. This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.	Director 30 April 2025		**Finding** There has been no formal review of first and second sign-off within the EJob Plan system. We were advised that Women's Services have undertaken a review of their sign-off details but have not corroborated this. Our review of the information has again identified test and generic details in the system that compromises data quality. Only the training module should be used for test data to preserve the integrity of the live system. **Revised Action, Responsibility and Timescale** Process for sign off included in policy, including timeframes for sign off at each stage. The training programs will ensure staff are aware of the process and time to sign off for each stage. A previous 'distant' sign off process has been approved by Local Negotiating Committee (LNC) and will continue within the revised JPP. However, Allocate does not currently facilitate 'distant' sign off. Health Medics team in discussion to ensure this is possible and that any test data is removed from live system. We currently have not received a timeframe for an upgrade of Allocate to facilitate this process. If Allocate are unable to provide the Health Board will need to find a 'work around' which would be in place within 6 months i.e., April 2026. **Executive Medical Director** **30 April 2026**
Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.				
5.	**Job Plan annual review** Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data.	Interim Medical Director and Deputy Director of People 30 April 2025	**High**	**Current status – Not implemented** **Finding** Our review of Health Board data as of 1 September 2025 showed overall compliance of 42% (Image 1 above) where job plans have been agreed and signed off.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work.			We have been advised that review dates have not been amended to reflect the individual's incremental date. It remains unclear how the Health Board will meet the 90% target of in-date job plans by 30 September 2025, set by Welsh Government. **Revised Action, Responsibility and Timescale** All Wales medical T&Cs advise that all relevant staff should have an in date and signed off job plan at least annually, with updated job plans if there is any significant change to the doctors working pattern or responsibility. This is clearly outlined in the draft policy. It will mean that job plans may not align to the doctor's incremental date. It is also anticipated that any change in operational structure recommended by Foundations for the Future cultural review may impact a number of individual job plan reviews. Monitoring via Power BI in place and allows for drill down by team (but not to individual staff level). The Health Board acknowledges that the target of 90% by September 2025 has not been met. This is primarily due to the delay with agreeing a revised JPP. The proposed trajectory for compliance is 50% end Q3, 75% end Q4, >90% by end Q1. This trajectory will be signed off at the Medical Workforce Group 15 October 2025 Monitoring of compliance would be as above, via local processes and at HB level at Medical Workforce Group and People and Culture Committee. **Executive Medical Director and Deputy Director of People** **30 October 2025**
6.	**Directorate/Specialty objectives are explicit** There is a generic statement within the Service Outcomes section of job plans *"To ensure service and*	Interim Medical Director 30 April 2025	**High**	**Current status – Not implemented** **Finding**

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	job plan aligned to deliver CPG and wider BCU Strategic direction", (sic). The Service Outcomes section overall was either incomplete or noted *"During job plan discussions need to review this"*. From our review, we are unclear how management are approving job plans without expected service objectives. We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.			We reviewed a sample of one job plan from the three Integrated Health Communities and the four pan North Wales clinical directorates. We found four (57%) were in-date and current, however none had any directorate or specialty service objectives recorded. **Revised Action, Responsibility and Timescale** The draft JPP outlines importance of service demand / capacity discussion *prior* to an individual job plan timetabling meeting. This will identify service priorities to align at job plan meeting. Individuals PDP from appraisals will inform service and personal priorities and objective for the coming year. The need for service priorities to be clearly articulated and aligned within individual job plans will be a core expectation for the training program and roadshows. Compliance with this element will need to be monitored via a quality assurance process which is beyond current capability of PowerBI monitoring. A sustainable automated solution will be in place within 6 months *if DDaT colleagues have the capacity to prioritise this work* It is anticipated that implementation of any operational structure following Foundations for the Future review may impact on a need to review service priorities and alignments. **Executive Medical Director** **30 April 2026**
Objective 3: Job plans include outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.				
7.	**Evidencing achievement of the Board objectives** Whilst there were strategic goals detailed in the Board Outcomes section of the job plan, they did not reflect the current strategic objectives, and there were no	Interim Medical Director 30 April 2025	**High**	**Current status – Implemented** **Finding** The review of the seven job plans confirmed that all had the current Health Board objectives recorded. In addition,

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	measurable outcomes agreed from which it could be evidenced as being worked to/achieved.			we found that three included Ministerial Priorities, with two also recoding the Values and Behaviours Framework.
Objective 4: Completed job plans reconcile to system records and session payments are correct.				
8.	**Regular review of payments to agreed job plan commitments** We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan. We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual review or simply roll-over. The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan.	Deputy Director of People 30 April 2025	**High**	**Current status – Not implemented** **Finding** The Medical Dental and Elements pay report has not been developed for use across the Health Board. We have been advised a dashboard has been produced in conjunction with the Office of the Medical Director (OMD), Surgical IHC West, Finance and People Services. We are advised a meeting was held on 19 August 2025 with a further meeting scheduled for 25 September 2025 but have not corroborated this or requested sight of the draft dashboard. **Revised Action, Responsibility and Timescale** Allocate is now linked to ESR to ensure sessions agreed reflect payment. An SOP to ensure implemented will be linked to policy and will be in place by December 2025. **Deputy Director of People** **31 December 2025**
Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance.				
10.	**Medical and Dental Job Plan reporting** There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance.	Deputy Director of People 30 April 2025	**High**	**Current status – Partially implemented** **Finding** The OMD Job Planning team send out a monthly *Job Planning Compliance* email that includes a link for the job planning dashboard to a pre-determined circulation. We are unclear whether this circulation captures all relevant leads with responsibility/accountability for job plan compliance.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
				We contacted the seven clinical service Directors to obtain details of their People and Culture meeting or to confirm where job plan performance and assurance was discussed. We received a reply for Centre, East and West IHCs and Women's Services but received no reply from Mental Health and Learning Disabilities, North Wales Managed Clinical Services or Cancer Services. We noted limited assurance reporting at a local level within IHC West on job planning. The West IHC Medical Director (Chair of the MWG) provided evidence of follow-up compliance with job plan completion to West operational leads. Women's Services hold monthly Centre, East and West Accountability Meetings where we noted job planning as an agenda item. We also noted a standing agenda item on the Clinical Directors bi-monthly meeting. Through our review of operational People and Culture meetings provided to us, we were unable to find any reference in the People Operations Report or any specific reporting on consultant job plan performance. **Revised Action, Responsibility and Timescale** Monthly compliance figures are circulated to operational teams and the divisional and IHC medical leaders. It is tracked at Medical Workforce Group at Health Board Level. A compliance escalation and dissemination pathway will be in presented for sign off at November's Medical Workforce Group to ensure clarity on information sharing and scrutiny. An assurance mechanism will be in place by the end of Quarter 4 Real time data is accessible via Allocate. How to access will form part of the Allocate 'how to' training. **Deputy Director of People** **31 March 2026**

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
11.	**Medical Workforce Group & People & Culture Executive Delivery Group (EDG)** The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it *"….will receive regular reports (on job plans) as per its Cycle of Business"* but we have been unable to verify they have actually received any reports for assurance recently. Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024). The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.	Deputy Director of People 30 April 2025	**High**	**Current status – Not implemented** **Finding** There is no evident reporting on consultant job plan performance to the Health Board's People and Culture Committee through the People Operations Report. We note a verbal update was provided to the Committee by the Interim Executive Medical Director at the 14 August 2025 meeting (Agenda Item PC25/82). The People & Culture Executive Delivery Group is still yet to be re-established. Consequently, assurance reporting from the Medical Workforce Group is not subject to any scrutiny or assurance to the Executive Committee and/or the Health Board People & Culture Committee. The Medical Workforce Group (MWG) is meeting regularly although we note its Terms of Reference require review as there has been a change in Chair that has not been reflected. A review of minutes has identified regular discussion on job plan performance. Of the minutes viewed, we noted the June 2025 meeting recorded *"action...to recirculate the Power BI link to ensure all members could access and monitor their compliance data."*. We note in July and August 2025 meetings a focus on the Welsh Government set target of 90% completed job plans by 30 September 2025 with the draft August 2025 minutes noting *"Current compliance was reported to be significantly below this target, prompting concern and a renewed focus on improvement."* **Revised Action, Responsibility and Timescale** Medical Workforce Group (MWG) is now chaired by an experienced medical leader who has developed Health Board Job Planning Policy in collaboration with LNC. It is the place where relevant care groups are held to account and where implementation of JP policy and relevant procedures will be monitored.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
				MWG will report to People and Culture Executive Delivery Group and thus to People and Culture Committee **Deputy Director of People** **31 October 2025**

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Betsi Cadwaladr University Health Board Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Report title:	**BCUHB Clinical Audit Forward Plan 2025-2026 (Tier 1 mandatory audits) and Audit plan for 2025-2026 (Tier 2 local "must do" audits)**		
Report to:	Audit Committee		
Date of Meeting:	16th December 2025		
Executive Summary:	**Tier 1 Clinical Audit Forward Plan 2025-2026** (national mandatory audit) addresses Clinical Audits and Outcome Reviews in which all Welsh Health Boards must participate (across sites where services are provided). Through having a structured forward plan will support our approach to clinical audit to ensure it drives meaningful quality improvement and risk management across the organisation. Prior to submitting to the Audit Committee, a paper went to Executive Committee for approval. **Tier 2 Audit Plan 2026-2026** addresses local must do audits, which have been based on Health Board risks and priorities, which we have developed a formal assessment that is undertaken and provides the rationale for the areas on the plan, which was a recommendation from the internal audit report February 2025. Following our processes, a review at six months was completed and four new audits were added to Tier 2 Audit Plan after formal assessment, presented at Strategic Clinical Effectiveness Group for discussion and agreement then Executive Quality Delivery Group for review and approval. The table has now been added within Appendix 1 as an update for the Audit Committee.		
Recommendations:	Following the recent Welsh Health Circular (WHC*) and update on NHS Wales national clinical audit and outcome review plan 2025 to 2026 the Audit Committee is asked to support the process that Betsi Cadwaladr as a Health Board:* ○ Ensure sufficient resources, governance, and structures to support full audit participation ○ Named Clinical Leads for each Tier 1 audit and support given to their involvement in national networks ○ Engage with people with lived experience to ensure audits reflect outcomes that matter to patients ○ Established formal processes currently being used to review audit findings, plan improvements, and escalate concerns to relevant parties ○ Promote shared learning from audits across the organisation and with patients ○ Support the organisation to embrace clinical audit to participate and ensure learning from outcomes ***Please note Appendix 1:*** • **Clinical Audit Forward Plan 2025- 2026** for Tier 1 mandatory audit, (which includes the list of national clinical audits and outcome reviews) which will form part of our process to develop monthly assurance reports that will be sent to IHCs and Divisions. • **Tier 2 Audit Plan for 2025- 2026** has been added to the forward plan with the additional four audits as referenced.		
Executive Lead:	Clara Day – Executive Medical Director		
Report Author:	Joanne Shillingford - Head of Clinical Effectiveness –		
Purpose of report:	*For Noting* ☐	*For Decision* ☐	*For Assurance* ☒

Assurance level:	*Significant* ☐ *High level of confidence/evidence in delivery of existing mechanisms/objectives*	*Acceptable* ☐ *General confidence / evidence in delivery of existing mechanisms / objectives*	*Partial* ☒ *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No Assurance* ☐ *No confidence / evidence in delivery*
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
Link to Strategic Objective(s):	• Objective 4 - Improving quality, outcomes and experience • Objective 5 - Establishing an effective environment for learning			
Regulatory and legal implications:	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.			
In accordance with WP7 has an EqIA been identified as necessary and undertaken?	N/A			
In accordance with WP68, has an SEIA identified as necessary been undertaken?	N/A			
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement			
Financial implications as a result of implementing the recommendations	N/A			
Workforce implications as a result of implementing the recommendations	N/A			
Feedback, response, and follow up summary following consultation	N/A			
Links to BAF risks:*(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement			
Reason for submission of report to confidential board (where relevant)	N/A			
Next Steps: Implementation of recommendations - *N*/A				
List of Appendices: Appendix 1 – Clinical Audit Forward Plan 2025-2026 and Tier 2 Clinical Audit Plan 2025-2026 following six-month update				

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Clinical Audit Forward Plan 2025/2026

for Tier 1 "mandatory" audits and Tier 2 "must do" local audits

EPILEPSY12
National Clinical Audit of Seizures and Epilepsies for Children and Young People

Royal College of Physicians | National Respiratory Audit Programme (NRAP)

NPDA
National Paediatric Diabetes Audit

NELA
National Emergency Laparotomy Audit

NATCAN
National Cancer Audit Collaborating Centre

NCEPOD

SSNAP
Sentinel Stroke National Audit Programme

NICOR

National Audit of Care at the End of Life

NJR
National Joint Registry
Working for patients, committed to excellence

PMRT
Supporting high quality local perinatal reviews

Royal College of Physicians | National Audit of Inpatient Falls (NAIF)

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS
NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

A Welsh Health Circular and Annual Plan is published in April each year to clarify the mandatory audit list. However, Betsi Cadwaldr University Health Board (BCUHB) Clinical Audit Forward Plan has been developed based on previous Welsh Health Circular and alterations may occur when final official release is made later in the year by Welsh Health Circular by Welsh Government.

Compliance Key

Key	***Comparison with National Benchmark*:**	***Comparison with Last BCUHB Report*:**
R	Where BCUHB reported performance is at or above the benchmark in fewer than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators (KPIs) according to the latest National audit report
A	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

TIER 1 Clinical Audits and Outcome Reviews in which all Welsh Health Boards must participate (across sites where services are provided)

National Audit	Audit period	Submission Deadline	Planned Report Publication	Speciality	2024/2025 publications			
					RAG Status against National Benchmark	RAG Status against Last BCU report	Assurance Level	Risk Level
Acute								
National Joint Registry (NJR)	Continuous data collection	N/A	September 2025	Trauma & Orthopaedics	No local reported data published in 2024/2025			
National Emergency Laparotomy Audit (NELA)	Continuous data collection	N/A	October 2025	Surgery / Anaesthetics	Green	Green	In progress at time of report	
Case Mix Programme (CMP) ICNARC	Continuous data collection	N/A	TBC	Anaesthetics	This report does not provide the level of data which the HB can measure against			
National Major Trauma Registry (NMTR)	Continuous data collection	N/A	TBC	Emergency Medicine	This report does not provide the level of data which the HB can measure against			
Older People								
Falls & Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service	Continuous data collection	N/A	January 2026	General medicine	Not registered to participate in this audit			
FFFAP: In-patient Falls Audit	Continuous data collection	N/A	October 2025	General medicine	Red	Green	**West**: Significant **Cent**: Significant **East**: Action plan overdue	**West**: Major **Cent**: Minor **East**: Action plan overdue
FFFAP: National Hip Fracture database	Continuous data collection	N/A	September 2025	Trauma & Orthopaedics	Amber	Green	In progress at time of report	
National Dementia Audit	Specific time period	TBC	December 2025	Mental Health	Amber	Green	Significant	Low

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

TIER 1 Clinical Audits and Outcome Reviews in which all Welsh Health Boards must participate (across sites where services are provided)

National Audit	Audit period	Submission Deadline	Planned Report Publication	Speciality	2024/2025 publications			
					RAG Status against National Benchmark	RAG Status against Last BCU report	Assurance Level	Risk Level
Sentinel Stroke National Audit Programme (SSNAP)	Continuous data collection	N/A	November 2025	Stroke	Amber	Amber	Limited	Moderate
Cancer								
National Audit of Metastatic Breast Cancer	Continuous data collection	N/A	September 2025	Breast Surgery / Cancer	Green	N/A – 1st publication	In progress at time of report	
National Audit of Primary Breast Cancer	Continuous data collection	N/A	September 2025	Breast Surgery / Cancer	Green	N/A – 1st publication	In progress at time of report	
National Bowel Cancer Audit (NBoCA)	Continuous data collection	N/A	October 2025	General Surgery / Cancer	Green	Green	In progress at time of report	
National Oesophago-Gastric Cancer Audit (NOgCA)	Continuous data collection	N/A	September 2025	General Surgery / Cancer	Green	Green	Full	None
National Lung Cancer Audit (NLCA)	Continuous data collection	N/A	April 2025	Respiratory Medicine / Cancer	Green	Green	Full	None
National Prostate Cancer Audit (NPCA)	Continuous data collection	N/A	October 2025	Urology / Cancer	Green	Green	Action plan overdue at time of report	
National Ovarian Cancer Audit	Continuous data collection	N/A	September 2025	Gynaecology	Red	N/A – 1st publication	Significant	Low
National Pancreatic Cancer Audit	Continuous data collection	N/A	September 2025	General Surgery / Cancer	Green	N/A – 1st publication	Full	None
National Non-Hodgkin Lymphoma Audit	Continuous data collection	N/A	September 2025	Oncology	Green	N/A – 1st publication	Significant	Low

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

TIER 1 Clinical Audits and Outcome Reviews in which all Welsh Health Boards must participate (across sites where services are provided)

National Audit	Audit period	Submission Deadline	Planned Report Publication	Speciality	2024/2025 publications			
					RAG Status against National Benchmark	RAG Status against Last BCU report	Assurance Level	Risk Level
National Kidney Cancer Audit	Continuous data collection	N/A	September 2025	Urology	Green	N/A – 1st publication	In progress at time of report	
Long Term Conditions								
Renal Registry	Continuous data collection (Clinical data)	N/A	July 2025	Renal Medicine	Green	Green	In progress at time of report	
National Early Inflammatory Arthritis Audit (NEIAA)	Continuous data collection & follow ups	N/A	October 2025	Rheumatology	Amber	No comparable data	In progress at time of report	
National Respiratory Audit Programme (NRAP): Adult Asthma	Continuous data collection (Clinical data)	N/A	June 2025	Respiratory Medicine	Red	No HB data submitted	In progress at time of report	
	Snapshot data collection (organisational)	Annually	November 2025	Respiratory Medicine	No comparable data	No comparable data	Action plan overdue at time of report	
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Continuous data collection (Clinical data)	N/A	June 2025	Respiratory Medicine	Green	Amber	**Cent**: Limited **West** & **East** – Action plan overdue	**Cent**: Moderate **West** & **East** – Action plan overdue
	Snapshot data collection (organisational)	Annually	November 2025	Respiratory Medicine	No comparable data	No comparable data	Action plan overdue at time of report	
NRAP: Children and Young People's Asthma	Continuous data collection (Clinical data)	N/A	June 2025	Paediatrics	Green	Green	**Cent**: Very Limited **West** & **East** – Action plan overdue	**Cent**: Moderate **West** & **East** – Action plan overdue

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

TIER 1 Clinical Audits and Outcome Reviews in which all Welsh Health Boards must participate (across sites where services are provided)

National Audit	Audit period	Submission Deadline	Planned Report Publication	Speciality	2024/2025 publications			
					RAG Status against National Benchmark	RAG Status against Last BCU report	Assurance Level	Risk Level
NRAP: Pulmonary Rehabilitation	Continuous data collection (Clinical data)	N/A	June 2025	Therapies	Amber	Green	In progress at time of report	
	Snapshot data collection (organisational)	Annually	November 2025	Therapies	No comparable data	No comparable data	In progress at time of report	
NRAP: Wales Primary Care Audit	Data obtained from GP practices in Wales	N/A	May 2026	Primary Care	Green	N/A – 1st publication	Action plan overdue at time of report	
Audiology Quality Standards	Continuous data collection	N/A	June 2025	Audiology	No report published in 2024/2025			
End of Life								
National Audit of Care at the End of Life (NACEL)	Jan – Dec 2024	December 2024	August 2025	Palliative Care / Medicine	No report published in 2024/2025			
Heart								
National Audit of Cardiac Rehabilitation (NACR)	Continuous data collection	N/A	TBC	Cardiology	Amber	Amber	In progress at time of report	
National Vascular Registry Audit (NVR)	Continuous data collection	N/A	November 2025	Vascular	Amber	Green	Limited	Moderate
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Continuous data collection	N/A	TBC	Cardiology	Amber	Amber	In progress at time of report	

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

TIER 1 Clinical Audits and Outcome Reviews in which all Welsh Health Boards must participate (across sites where services are provided)

National Audit	Audit period	Submission Deadline	Planned Report Publication	Speciality	2024/2025 publications			
					RAG Status against National Benchmark	RAG Status against Last BCU report	Assurance Level	Risk Level
NCAP: National Audit of Cardiac Rhythm Management (CRM)	Continuous data collection	N/A	TBC	Cardiology	Green	Amber	In progress at time of report	
NCAP: National Audit for Percutaneous Coronary Intervention (PCI)	Continuous data collection	N/A	TBC	Cardiology	Amber	Amber	In progress at time of report	
NCAP: National Heart Failure Audit	Continuous data collection	N/A	TBC	Cardiology	Amber	Green	In progress at time of report	
Mental Health								
National Clinical Audit of Psychosis	Online data submission and From January 2026 this will be monthly reporting of our compliance	N/A	February 2026	Mental Health	Green	Green	In progress at time of report	
Women and Children's Health								
The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Series of data collection cohorts within this audit	Various deadlines for cohorts	July 2025	Paediatrics	Amber	Amber	Significant	Low
National Maternity & Perinatal Audit (NMPA)	Continuous data collection	N/A	September 2025	Women's Services	No report published in 2024/2025			

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

TIER 1 Clinical Audits and Outcome Reviews in which all Welsh Health Boards must participate (across sites where services are provided)

National Audit	Audit period	Submission Deadline	Planned Report Publication	Speciality	2024/2025 publications			
					RAG Status against National Benchmark	RAG Status against Last BCU report	Assurance Level	Risk Level
National Neonatal Audit Programme (NNAP)	Continuous data collection	N/A	October 2025	Paediatrics	Amber	Amber	In progress at time of report	
National Perinatal Mortality Review Tool	Continuous data collection	N/A	September 2025	Women's Services	No comparable data	No comparable data	In progress at time of report	

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

The Clinical Outcome Review Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme
MBRRACE – Perinatal Mortality Surveillance operates	2023	Operates continuous data capture	08/05/2025	Maternal, Newborn and Infant Clinical Outcome Review Programme
MBRRACE – Saving Lives Improving Mothers Care	2021/2023	Operates continuous data capture	11/09/2025	Maternal, Newborn and Infant Clinical Outcome Review Programme
MBRRACE – Perinatal Confidential Enquiry	TBC	Operates continuous data capture	TBC	Maternal, Newborn and Infant Clinical Outcome Review Programme
National Confidential Inquiry into Suicide and Safety in Mental Health	Operates continuous data capture	N/A	April 2026	Mental Health & Learning Disabilities Programme

Rib Fractures (RI)	2025/2026	Ongoing	TBC	Trauma & Orthopaedics
Acute Illness in People with Learning Disabilities (AIPLD)	2025/2026	Ongoing	TBC	Mental Health &b Learning Disabilities Programme
Stabilisation of the Critically ill Child (SCIC)	2025/2026	Ongoing	TBC	Critical Care
Pleural Procedures (PP)	2025/2026	Ongoing	TBC	Respiratory
Abnormal Blood Sodium (ABS)	2024/2025	Study complete	Publication anticipated October 2025	Vascular Surgery
Emergency Paediatric Surgery (EPS)	2024/2025	Study complete	Publication anticipated December 2025.	Trauma & Orthopaedics

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

Tier 2 - local must do audits (Approved through EQDG 13th October)

Reference No:	Project Title	Internal Guidance	Corporate Policy	External Guidance	Reaudit?	On Risk Register	Which BCUHB priority does this support?	Proposed Start Date	Proposed Finishing Date	Objectives	Accountable Lead(s)	Responsible Corporate Group
1	DNACPR Audit	Y	Y	N	Y	N	Decision-making/EOL care	Quarter 2, 2025	TBC	Ensuring compliance against All Wales DNACPR policy, which in turn will develop relevant pathways/standard operating procedures as appropriate. Improving documentation of DNACPR and communication with Primary Care. Ensure appropriate Mental Capacity assessment.	Dr Ben Thomas, AMD Law and Ethics	Consent Group
2	Antimicrobial Point Prevalence Audit (Inpatients)	Y	N	Y	Y	Y	Keeping People Safe from Avoidable Harm	Nov-25	November 2025 Published by PHW March 2026	To improve compliance and local improvement plans	Zoe Kennerley, Pharmacist	Antimicrobial Steering Group
3	Root Cause Analysis Hospital Acquired Thrombosis (RCA HAT)	Y	Y	Y	Y	Y	Keeping People Safe from Avoidable Harm	Jan-25	Ongoing audit with quarterly reporting schedule	Ensuring compliance against All Wales policy, improving patient experience and patient safety	Delyth Williams Houston (Lead Thrombosis Nurse Specialist)	Patient Safety Group
4	Non-Medical Prescribing (NMP)	Y	Y	Y	Y	N	Keeping People Safe from Avoidable Harm	April 2025	November 2025	To support and improve compliance for the quality standards detailed within MM03	Judith Green (Lead Governance Pharmacist)	Patient Safety Group
Added at 6 monthly review of Tier 2 Audit Plan Sept/Oct 2025 5	CPE screening	Y	N	Y	Y	N	Keeping People Safe from Avoidable Harm	Twice yearly September 2025 March 2026	TBC	To improve CPE screening compliance to avoid clinical infection from occurring (infections with limited treatment options) and exposing other patients to CPE reducing also the risk of bay/ward closures and lost bed days.	Andrea Ledgerton discussion held 25/09 to monitor on AMaT	Infection Prevention Team
6	MRSA screening and decolonisation	Y	N	Y	Y	N	Keeping People Safe from Avoidable Harm	Twice yearly June 2025 December 2025	TBC	To improve MRSA screening compliance which will in turn help to assist in early detection of MRSA colonisation to subsequently prevent infection from occurring and transmission to other patients	Andrea Ledgerton discussion held 25/09 to monitor on AMaT	Infection Prevention Team

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/2026

7	Catheter Associated Urinary Tract Audit	Y	N	Y	Y	N	Keeping People Safe from Avoidable Harm	6 monthly audit July 2025	March 2026	To determine a catheter associated urinary tract infection rate and to improve compliance with the insertion and ongoing management of urinary catheters to prevent and reduce infections.	Andrea Ledgerton discussion held 25/09 to monitor on AMaT	Andrea Ledgerton
8	Peripheral Vascular Device Audit	Y	N	Y	Y	N	Keeping People Safe from Avoidable Harm	Twice yearly September 2025 March 2026	TBC	Improve compliance with the insertion and ongoing management of peripheral vascular devices	Andrea Ledgerton discussion held 25/09 to monitor on AMaT	Andrea Ledgerton
(Noted for 2026)	Peer review of consent to examination and treatment process	Y	Y	N	Y	N	Keeping People Safe from Avoidable Harm and following correct processes	Quarter 2 2026	TBC	Due to resource implications and lack of engagement, the plan is to complete consent peer reviews every 2 years with next cycle planned for 2nd quarter 2026. Feedback has suggested that there is more capacity to complete in 2nd quarter.	Dr Ben Thomas, AMD Law and Ethics & IHC Medical Directors	Consent & Capacity Strategic Working Group

Teitl adroddiad: ***Report title:***	Statutory Compliance Report			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Committee with: • an update on compliance activities, including: ➢ internal and external audits ➢ regulatory body reviews ➢ policy management ➢ UK Covid-19 Inquiry and Thirlwall Inquiry.			
Argymhellion: ***Recommendations:***	The Committee is asked to: • **NOTE** the content of the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Glesni Driver, Head of Statutory Compliance and Inquiries			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
The Statutory Compliance arm of the Corporate Governance Directorate ensures compliance to duties relating to laws, regulations, and statutory requirements set by the government and regulatory bodies, audit and non-audit bodies, and statutory inquiries.				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Building an Effective Organisation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with statutory compliance requirements
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has a SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	Not applicable, other than those relating to individual regulatory body reviews and audit reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual regulatory body reviews and audit reports
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual regulatory body reviews and audit reports
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report has been prepared as an amalgamated report of all compliance-related requirements
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable, other than those relating to individual regulatory body reviews and audit reports
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

Regular updates on audit, regulatory body reviews, policy management and legislation will be submitted to the Executive Committee and Audit Committee.

Rhestr o Atodiadau:

List of Appendices:

- Appendix 1 – Internal Audit – open 'unsatisfactory' assurance recommendations
- Appendix 2 – Internal Audit – open 'limited' assurance recommendations
- Appendix 3 – Internal Audit – recommendations approved for closure - summary
- Appendix 4 – Audit Wales – open recommendations
- Appendix 5 – Audit Wales – closure summary
- Appendix 6 – Policy Management – all overdue policies
- Appendix 7 – Ministerial Directions
- Appendix 8 – Welsh Health Circulars

Contents

BETSI CADWALADR UNIVERSITY HEALTH BOARD
STATUTORY COMPLIANCE REPORT

1. INTRODUCTION

This report provides an update on statutory compliance activities, including internal and external audits, compliance with regulatory body reviews, updates on policy management, and national inquiries.

2. INTERNAL AUDIT

2.1 Internal Audit – new audit reports

Table 1 below shows all the Internal Audit reports received up to 27th October 2025.

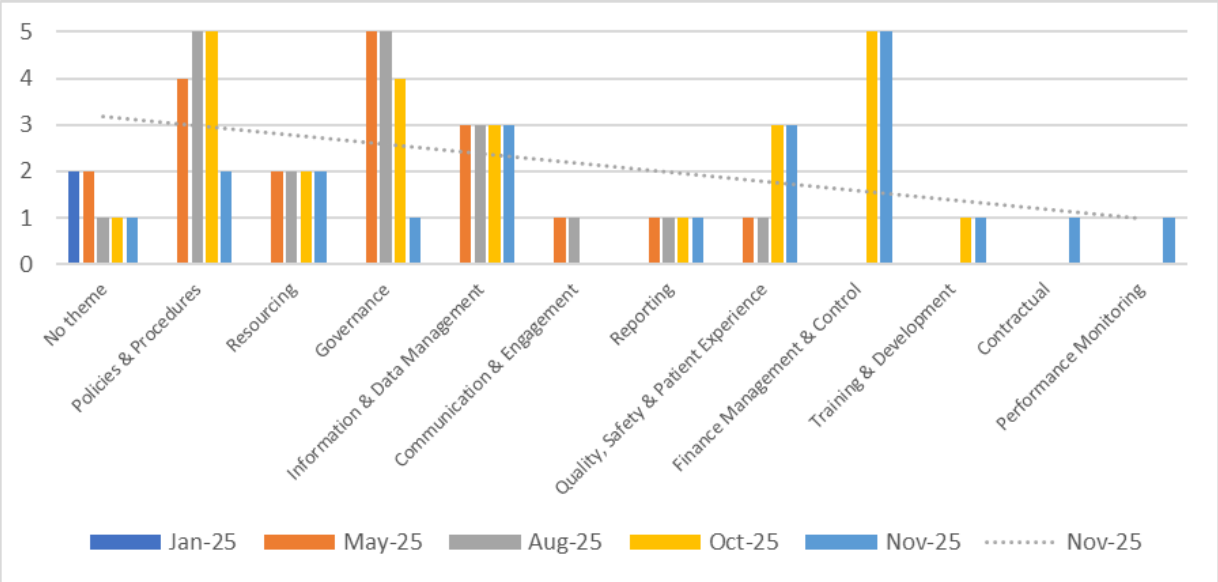
Reasonable	Patient Experience
Reasonable	Public Health – Grant funded activity
N/A	Consultant Job Planning - Follow-up
Reasonable	Digital Benefits and Change

2.2 Internal Audit – open 'Unsatisfactory' assurance recommendations

Table 2 below shows a summary, by Executive, of all open 'unsatisfactory' assurance recommendations, the number of these overdue their original implementation date, and number approved for closure by the Executive Committee on 26th November 2025. The table also includes the total number of high priority recommendations overdue their original implementation date by 6 months or more (as at 2nd October 2025):

Executive Lead	'Unsatisfactory' assurance recs - open	Open 'unsatisfactory' assurance recs overdue original implementation	High priority recs overdue original implementation date by 6 months or more	Total 'unsatisfactory' assurance recs put forward for closure
Chief Executive	1	1	1	0
Executive Medical Director; Deputy Director of People	5	5	3	1
Executive Medical Director	7	0	0	0
Executive Director of Finance	6	2	0	1
Chief Operating Officer	3	2	1	0
Total	**22**	**10**	**5**	**2**

Graph 1 below shows the trend of open unsatisfactory recommendations per theme during 2025.



A copy of all open 'unsatisfactory' assurance recommendations is included in Appendix 1.

2.3 Internal Audit – open 'Limited' assurance recommendations

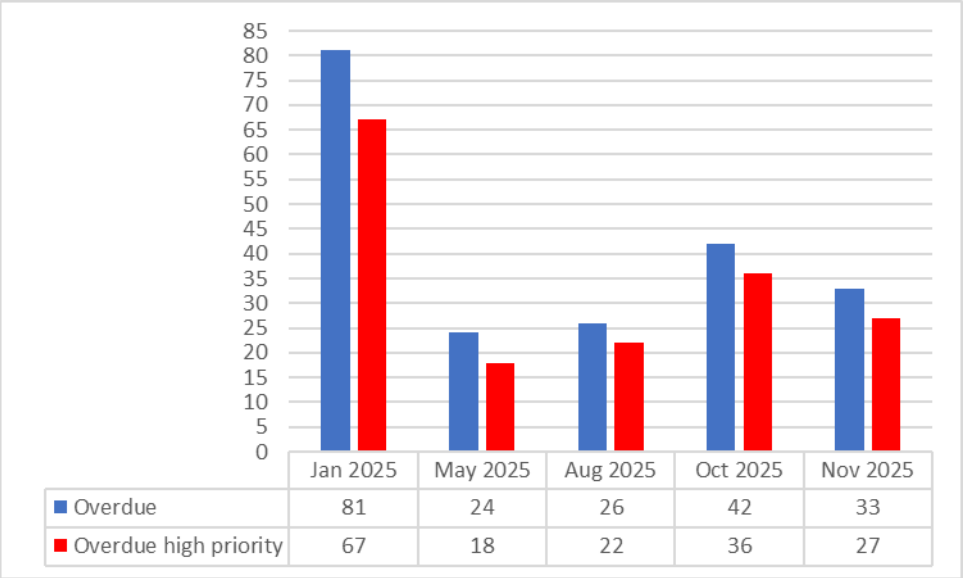
Table 3 below shows a summary, by Executive, of all open 'limited' assurance recommendations, the number of these overdue their original implementation date, the high priority recommendations overdue their original implementation date by 6 months or more, and number approved for closure by the Executive Committee on 26th November 2025 (as at 2nd October 2025):

Executive Team Member	Total 'Limited' assurance recs - Open	Open 'Limited' assurance recs overdue original implementation date	High priority recs overdue original implementation date by 6 months or more	'Limited' assurance recs put forward for closure
Executive Director of Nursing	9	7	0	6
Chief Executive	3	3	1	0
Chief Operating Officer	8	5	0	5
Deputy Director of People	2	2	0	0
Director of Corporate Governance	5	1	0	4
Executive Director of Finance	4	4	0	3
Executive Medical Director	4	4	3	0
Executive Medical Director; Deputy Director of People	1	1	0	0
Chief Digital and Information Officer	3	0	0	0
Director of Partnerships, Engagement and Communications	2	2	0	9
Executive Director of Public Health	4	0	0	0
Director of Environment and Estates	5	5	3	0
Total	**50**	**34**	**7**	**27**

A copy of all open 'limited' assurance recommendations is included in Appendix 2.

2.3.1 High priority limited recommendations

Graph 2 below shows all overdue limited assurance recommendations as reported to the Audit Committee meetings during 2025, and of those overdue, the 'high priority' total.



2.4 Internal Audit – approved recommendations for Committee review

Table 4 below provides a summary of all recommendations approved for closure by the lead Executive Team Member and Executive Committee on 26th November 2025. These will now be shared with the relevant audit body for review.

Executive Lead	Approved for closure by Executive	Awaiting approval by Executive
Chief Digital and Information Officer	5	
Chief Executive		1
Director of Corporate Governance	4	
Chief Operating Officer	5	
Executive Director of Nursing	8	
Director of Partnerships, Engagement and Communications	9	
Interim Executive Medical Director; Deputy Director of People	1	
Executive Director of Finance	8	
Total	**40**	**1**

A summary of the closure narrative for each of the recommendations is included in Appendix 3.

2.5 Internal Audit – recommendations returned for further evidence

As previously reported, work continues to source feedback on audit recommendations requiring further evidence to support closure following submission to the Executive Team Members and recommendation owners. When this information is available, it will be returned to Internal Audit for further review.

3. AUDIT WALES

3.1 Audit Wales – new audit reports

The 'Urgent and Emergency Care: Arrangements for Managing Demand' audit report has been published since the last update, and recommendations added to the tracker (as at 6th November 2025).

3.2 Audit Wales – open recommendations

The details of all the open Audit Wales recommendations are included in Appendix 4.

Table 5 below shows the number of Audit Wales recommendations overdue their original implementation date by 6 months or more (as at 2nd October 2025):

Report Title	Number overdue original implementation date - 6 months or more	Lead Executive Team Member
Structured Assessment 2022	1	Chief Digital and Information Officer
Structured Assessment 2023	2	Director of Corporate Governance
Board Effectiveness Follow-up – Betsi Cadwaladr University Health Board	1	Chief Executive
Review of Cost Savings Arrangements	2	Executive Director of Finance
Urgent and Emergency Care: Flow out of Hospital – North Wales Region	3	Chief Operating Officer
Total	**9**	

3.3 Audit Wales – approved recommendations for Committee review

Table 6 below provides a summary of the recommendations approved for closure by the lead Executive Team Member, and Executive Committee on 26th November 2025, which will now be shared with Audit Wales for review.

Executive Lead	Approved for closure by Executive
Executive Director of Finance	2
Total	**2**

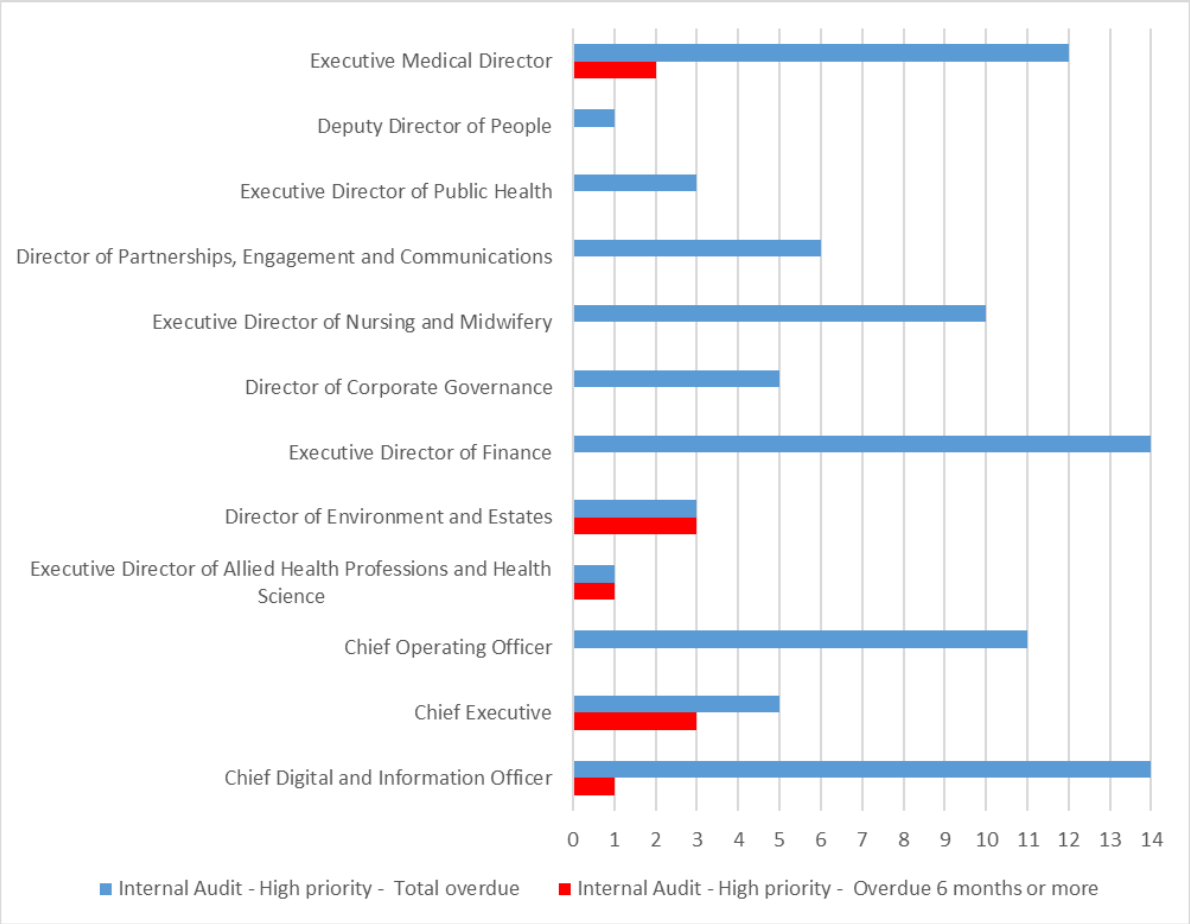
A summary of the closure narrative for each of the recommendations is included in Appendix 5.

4. AUDIT - OVERVIEW

4.1 Summary of all audit recommendations

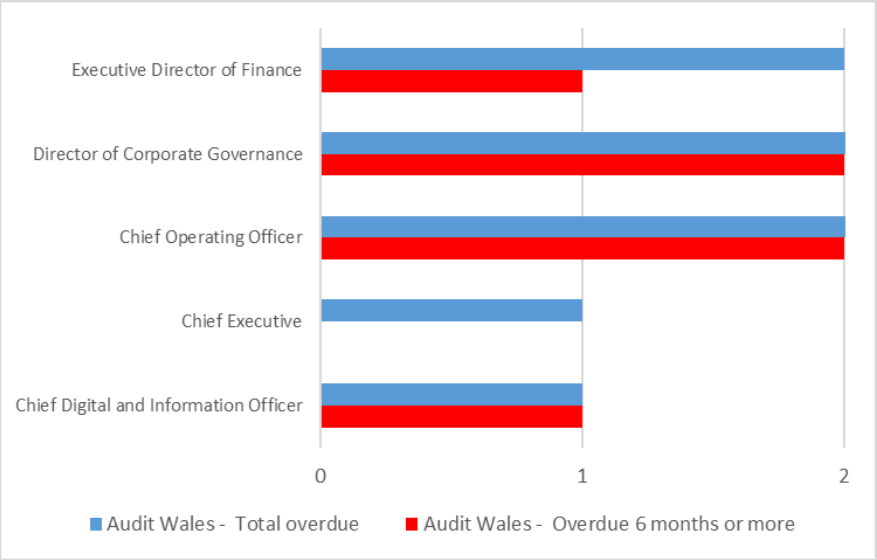
4.1.1 Internal Audit - Open and overdue 'high priority' recommendations

Graph 3 below provides details of all open 'high priority' Internal Audit recommendations overdue the original implementation, and the number overdue by 6 months or more (as at 2nd October 2025), listed by Lead Executive Team Member.



4.1.2 Audit Wales - open and overdue recommendations

Graph 4 below provides details of all open Audit Wales recommendations including the number that are overdue the original implementation date by 6 months or more (as at 2nd October 2025), listed by Lead Executive Team Member.



4.2 Overview of all recommendations

Table 7 below provides a summary of all recommendations, and their position in the closure approval process.

	As at 14/03/2025	As at 24/04/2025	As at 29/07/2025	As at 29/07/2025	As at 02/10/2025
New Internal Audit recommendations	46	60	98	20	20
New Audit Wales recommendations	8	24	0	0	17
Pending - Executive Committee	0	0	0	31	31
With Internal Audit for review	0	0	0	8	0
With Audit Wales for review	0	0	0	8	0

4.3 Re-profiling of historic and unmanageable items

The Corporate Governance Directorate has not been made aware that there are any recommendations that need consideration as no longer relevant.

4.4 Realignment of audit recommendations

The remaining open recommendations relating to the 'Contracted Patient Services: Quality and Safety Arrangements - Follow-up' audit report have been reassigned to the Executive Director of Finance as lead Executive, with those relating to quality progressed by the Executive Director of Nursing and Midwifery.

The 'Performance Management Framework and Reporting' audit report has been reassigned to the Executive Director of Finance, as of November 2025.

5. REGULATORY BODY REVIEWS (NON-AUDIT BODIES)

5.1 HEALTHCARE INSPECTORATE WALES

5.1.1 Published Reports (0)

There are no published reports for this period.

5.1.2 Announced/Unannounced Inspections (1)

Health Inspectorate Wales (HIW) undertook an inspection at Hergest Ward, Ysbyty Gwynedd between 8th and 10th September 2025. No immediate assurances were issued. The Health Board awaits the improvement plan and draft inspection report from HIW.

5.1.3 Concerns/Requests for Assurance (2)

Emergency Department at Wrexham Maelor, IHC East

HIW have raised concerns in September 2025.

The Health Board issued a response to HIW on 16th September 2025 to confirm:

- Staffing levels were fully established across medical and nursing teams
- Reinforced patient confidentiality protocols have been undertaken with staff
- Dynamic risk assessments are maintained and prioritised patients with greatest clinical need
- Allocated staff are in place to monitor patients outside cubicles and escalate concerns
- Commitment to improving patient communication during periods of extreme demand.

These actions aim to ensure safe care delivery and mitigate future risks under high-pressure conditions.

Hergest Ward, Ysbyty Gwynedd, Mental Health and Learning Disabilities

HIW raised concerns following an incident involving a detained patient at the Hergest Unit. HIW is seeking assurance from the Health Board on clinical decision-making, risk assessment processes, and protocols for managing leave in high-risk cases. The Health Board will provide the response as requested by 3rd November 2025.

All responses from the Health Board receive approval from Responsible Directors and the appropriate Executive Director, prior to submission to HIW. These are subject to oversight and monitoring via the Health Board's Regulatory Assurance Group (RAG), which reports to the Executive Delivery Group (EDG).

5.2 CARE INSPECTORATE WALES

5.2.1 Quality of Care Review Visit

Review Visit relating to Enhanced Community Residential Services, Mental Health and Learning Disabilities, Mold (East) took place on 4th July 2025.

The visit was undertaken by the Health Board's designated Responsible Individual (Head of Quality), in line with the Regulation and Inspection of Social Care (Wales) Act 2016.

No immediate patient safety issues were identified and recommendations have been made in relation to minor areas for improvement.

Once the improvement plan is completed by the service, the actions will be captured on the Health Board's AMaT system for monitoring and tracking.

5.3 QUALITY PEER REVIEWS

No activity to report.

5.4 HEALTH AND SAFETY EXECUTIVE/LOCAL AUTHORITY

No activity to report.

5.5 PUBLIC SERVICES OMBUDSMAN FOR WALES

5.5.1 Public Interest Reports (PIRs)

The Health Board has 1 ongoing Public Interest Report issued by the Ombudsman. PIR received March 2025 (Case ref ID2087 / 202301141)

Status: Overdue

Progress Update: 8 of the actions have been completed with 1 remaining action overdue which was due 25th September 2025. The final recommendation in relation to implementing a Commissioning Assurance Framework (CAF) is overdue. The Health Board has requested an extension due to a change to the approach of the work required. The Quality team have informed the Ombudsman's Office of the reasons for the change in approach, the revised timescale and are liaising with the Ombudsman to agree a realistic deadline.

The Health Board is on track with the action plan, reporting progress to the Health Board's Regulatory Assurance Group, Executive Delivery Group and Quality, Safety and Experience (QSE) Committee.

5.5.2 **Learning from the Ombudsman**

The Quality Team continue to collaborate with other Health Boards via the NHS Wales Ombudsman Safety & Learning network to review published reports and discuss themes for wider learning, working to improve how it captures, tracks and monitors Ombudsman recommendations and compliance.

When a Health Board complaint is upheld by the Ombudsman, the final report findings and recommendations are presented to the Patient Safety Group and Clinical Effectiveness Group for discussion. The Health Board also continue to meet with the Ombudsman's Office quarterly, with the next meeting scheduled for January 2026.

6. POLICY MANAGEMENT

6.1 Executive Policy Oversight Group policy approvals

Table 8 below lists the policy reviewed and approved by the Executive Policy Oversight Group (EPOG) since the last update. Once approved, this policy will be published on BetsiNet by the Statutory Compliance Team, pending any actions from the Group being completed. The Group is chaired by the Director of Corporate Governance.

Policy Name and reference	Lead Executive Team Member
MHLD 0029 Perinatal Mental Health Service Operational Policy	Executive Director of Allied Health Professions & Health Science

6.2 High-risk overdue policies update

The Audit Committee requested an update on overdue policies that posed the highest risk to the Health Board. All policies overdue their review date pose a risk to the Health Board, however, those relating to 'patient safety' were identified as those posing the highest risk as there is a potential direct impact on the safety of patients. The Statutory Compliance Team has undertaken an ongoing review and request for updates on progress around policies overdue a review.

Table 9 below provides details of the overdue policies relating to patient safety as at 28th October 2025.

Name	Review Date	Responsible Director
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	01/09/2019	Chief Operating Officer
MD01 - Policy on Consent to Examination or Treatment (Based on the All Wales Model Policy) .pdf	01/09/2025	Executive Medical Director
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	01/09/2021	Executive Medical Director
MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	01/03/2024	Executive Director of Allied Health Professions and Health Science
MHLD 0026 - Policy for Admission, Receipt and Scrutiny of Statutory Documentation.pdf	29/04/2025	Executive Director of Allied Health Professions and Health Science
MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	01/07/2020	Executive Director of Allied Health Professions and Health Science
MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf	01/06/2019	Executive Director of Allied Health
MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf	01/04/2021	Executive Director of Allied Health Professions and Health Science
MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	15/01/2024	Executive Director of Allied Health Professions and Health Science
MM01 - BCUHB Medicines Policy .pdf	31/12/2023	Executive Medical Director
MM02 - Injectable Medicines Policy.pdf	08/07/2022	Executive Medical Director
MM03 - Procedure for Supplementary (SP) and Independent (IP) Prescribers (1).pdf	01/04/2025	Executive Medical Director
MM05 - Intrathecal Chemotherapy Policy - V3.pdf	01/03/2021	Executive Medical Director
MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf	01/02/2022	Executive Medical Director
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	01/05/2021	Executive Medical Director
NU28 - Nurse Staffing Levels Policy.pdf	01/01/2025	Executive Director of Nursing
RD02 - Policy for Research Involving Ionising & Non Ionising Radiation.pdf	25/05/2025	Executive Medical Director
RES03 - Cardiopulmonary Resuscitation (CPR) Policy.pdf	31/08/2025	Executive Medical Director

Appendix 6 provides a full list of all overdue policies as at 28th October 2025, and progress updates provided up to that date, where provided.

6.3 Overdue procedures and written control documents

The Statutory Compliance Team continues to work with lead Executive Team Members to progress overdue procedures and other written control documents (WCDs).

The WCD information includes all procedures, guidelines, procedures, protocols, strategies and 'other' documents currently listed on the Policy Management System.

6.4 Overdue policy-documents – by Executive

Table 10 below provides the total number of all policies, WCDs, and all-Wales documents.

	Policies			Other WCDs			All Wales		
	Total	Overdue	% overdue	Total	Overdue	% overdue	Total	Overdue	% overdue
Chief Digital Information Officer	4	0	0%	26	4	15%			0%
Chief Executive			0%	1	0	0%			0%
Chief Operating Officer	6	1	17%	144	55	38%	6	3	50%
Director of Corporate Governance	4	2	50%	16	4	25%			0%
Director of Environment and Estates	7	5	71%	3	3	100%			0%
Director of Partnerships, Engagement and Communications			0%	1	1	100%			0%
Executive Director of Allied Health Professions and Health Science	29	9	31%	83	42	51%	3	0	0%
Executive Director of Finance	2	1	50%	15	3	20%			0%
Executive Director of Nursing and Midwifery	8	2	25%	112	9	8%	7	5	71%
Executive Director of Public Health			0%	12	2	17%			0%
Executive Director of Workforce and Organisational Development	28	6	21%	68	12	18%	5	1	20%
Executive Medical Director	12	12	100%	177	56	32%	9	2	22%
	100	**38**	**38%**	**658**	**191**	**49%**	**30**	**11**	**37%**

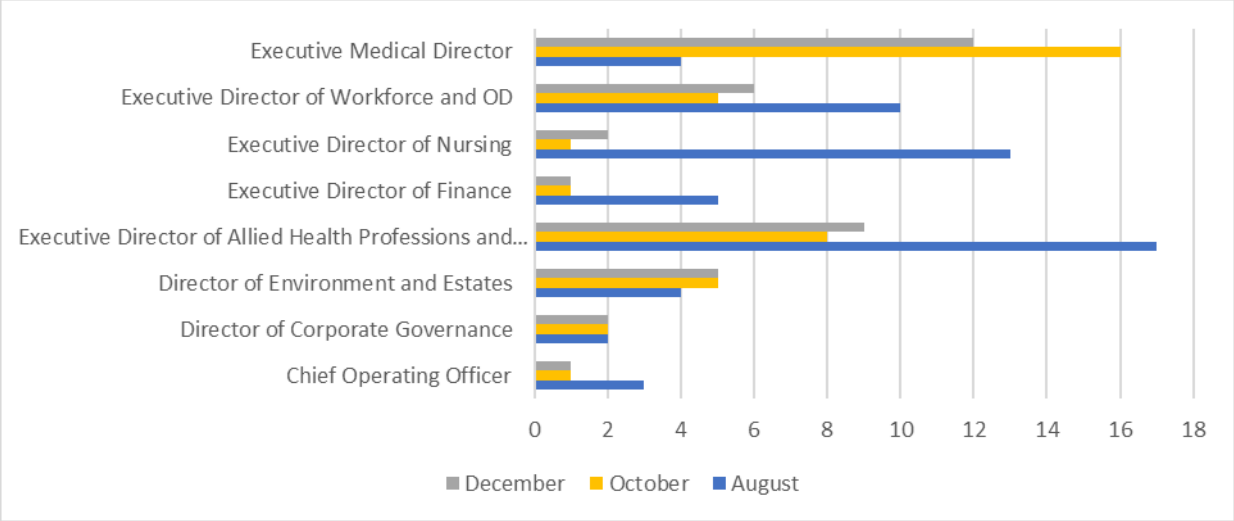
The total number of policies exclude any all-Wales documents, and also only includes a total of one document where there is both a Welsh and English version available. This total also excludes any appendices aligned to a policy, which are currently separately on the Policy Management System (PMS).

It only includes a total of one document where there is both a Welsh and English version available. This total excludes any appendices aligned to any WCD, which are currently listed separately on the Policy Management System.

The all-Wales document information includes every all-Wales policy and WCD, but excludes all appendices listed separately on the PMS, and also only include a total of one document where there is both a Welsh and English version available. Again, this total excludes any appendices aligned to any all-Wales documents, which are currently listed separately on the PMS.

Graph 5 below provides a comparison of the number of overdue policy documents, by Executive. If an Executive is not listed, there are no overdue policy assigned to that Executive.

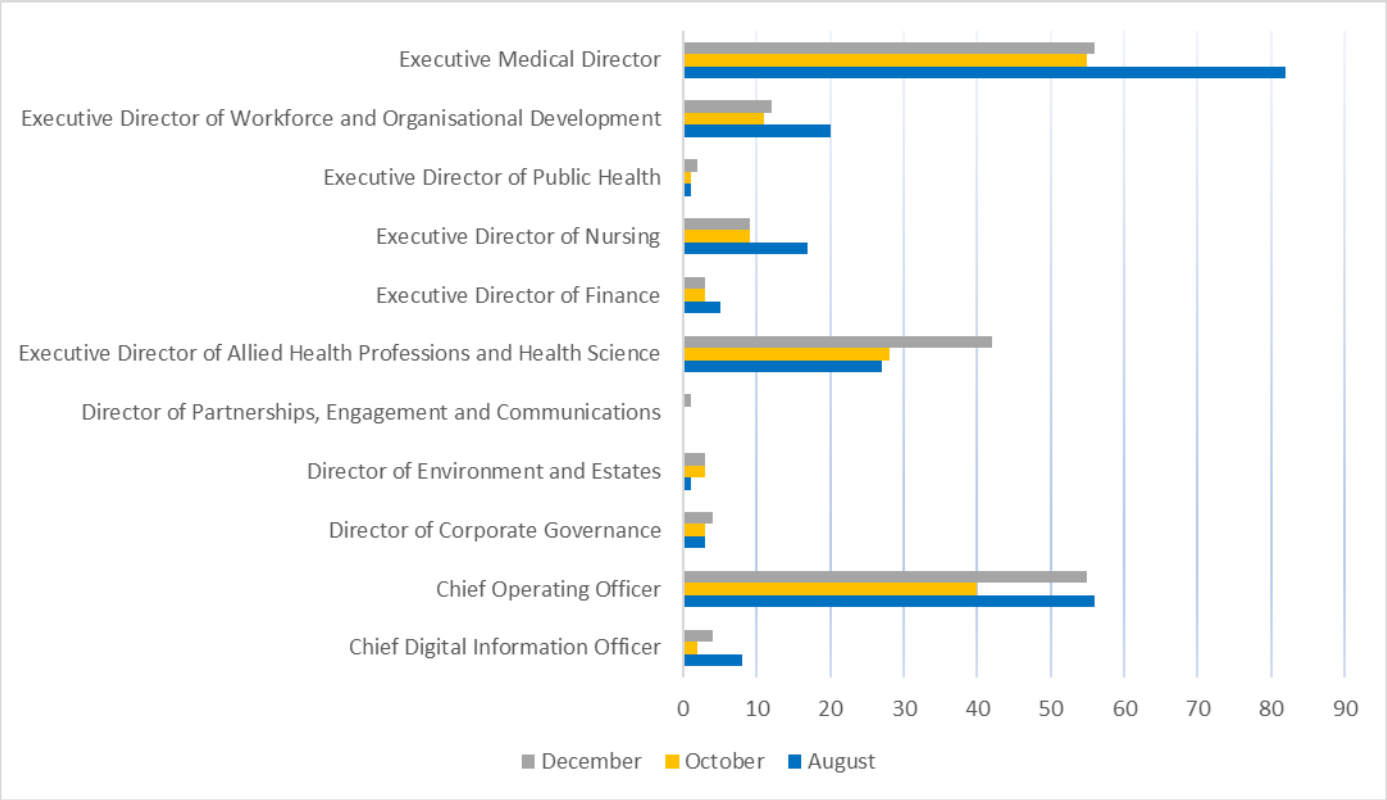
Please note that the reference to August, October and December in the following graphs refers to Audit Committee meetings.



There is improvement in the total number of overdue policies from that previously reported in some areas, but still work to be done to reduce the number of those overdue their review date.

6.5 Overdue WCD-documents – by Executive

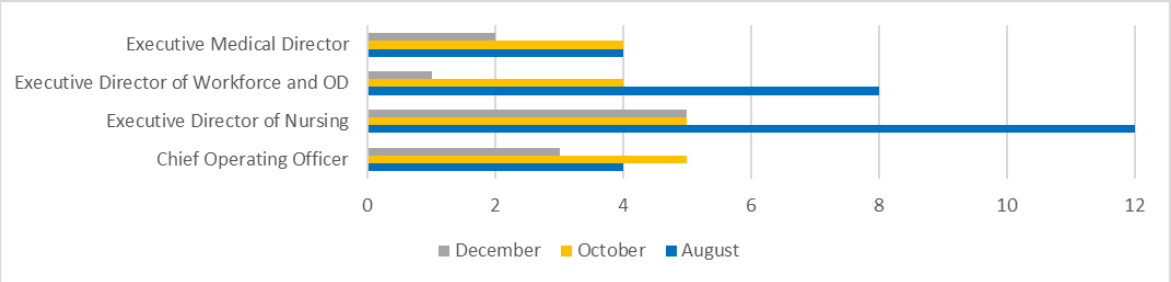
Graph 6 below provides a comparison of the number of overdue WCDs, by lead Executive Team Member. If a lead Executive Team Member is not listed, there are no overdue written control documents assigned to that Executive.



There is improvement in the total number of overdue procedures from that previously reported in some areas, but still work to be done to reduce the number of those overdue their review date.

6.6 Overdue all-Wales policy-documents – by Executive

Graph 7 below provides a comparison of the number of overdue all-Wales policies and WCDs, by Executive. If an Executive is not listed, there are no overdue written control documents assigned to that Executive.



There is a marked improvement in the total number of overdue all-Wales policy-related documents, appreciating that much of this is outside the Health Board's control.

As reported at the August Audit Committee, the Health Board should produce its own policy documents if there is a delay in the implementation of any all-Wales documents.

7. MINISTERIAL DIRECTIONS AND WELSH HEALTH CIRCULARS

As previously reported, Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) contain important information that the Health Board need to review and enact if required. The 2023 'Office of the Board Secretary Review' contained a recommendation to *'Review the management of WHCs and MDs to ensure these are tracked through Committees in terms of the compliance achieved against each for onward assurance to the Board'.*

The Corporate Governance Directorate has responsibility for maintaining a library of all WHCs and MDs received, the name of the identified lead Executive Team Member, and to capture actions being undertaken to ensure implementation and compliance.

This is the second in the twice-yearly update to the Audit Committee, and provides an update from 1st April 2025 to 30th September 2025.

7.1 MINISTERIAL DIRECTIONS

A total of 11 MDs were received between 1st April 2025 to 30th September 2025. All these have been shared with the relevant lead Executive Team Member to review and identify any necessary actions.

A copy of the Legislation Library containing the MDs received, together with a summary status update as at 1st October 2025 is included in Appendix 7.

7.2 WELSH HEALTH CIRCULARS

A total of 23 WHCs were received between 1st April 2025 to 30th September 2025. All these have been shared with the relevant lead Executive Team Member to review and identify any necessary actions.

A copy of the Legislation Library containing the WHCs received, together with a summary status update as at 1st October 2025 is included in Appendix 8.

8. STATUTORY INQUIRIES

8.1 UK COVID-19 INQUIRY

The UK Covid-19 Inquiry is split into 10 different investigations – or 'Modules' – which examine different parts of the UK's preparedness for and response to the pandemic and its impact. The below provides the latest update in relation to the Inquiry.

Module 8 - Children and Young People

Since the last update, the hearings for the Module 8 investigation into the impact of the pandemic on children and young people has taken place, ending on 23rd October 2025. That investigation explored the diverse experiences of children and young people, including those who were disproportionately impacted by the pandemic because of their personal or family circumstances. The module assessed how well decision-makers considered the impact on children and young people, to ensure lessons are learned to protect future generations.

The Chair will now consider this oral evidence, together with a wealth of written evidence including the 'Every Story Matters' Children and Young People Record and the Children and Young People's Voices research before making her findings and recommendations.

Publication of 2nd Module 2, 2A, 2B and 2C report

The Inquiry published its second report and recommendations following its investigation into the 'Core decision-making and political governance' on 20th November 2025. It looked into core political and administrative governance and decision-making. It includes initial response, central government decision making, political and civil service performance as well as the effectiveness of relationships with governments in the devolved administrations and local and voluntary sectors.

The UK Covid-19 Inquiry has found that the response of the four governments was a repeated case of 'too little, too late'.

Lockdowns in 2020 and 2021 undoubtedly saved lives, but only became inevitable because of the acts and omissions of the four governments.

A number of key findings were identified in under the following headings:

- The emergence of Covid-19
- The first UK-wide lockdown
- Exiting the first lockdown
- The second wave
- The vaccination rollout and Delta and Omicron variants.

A number of key themes were identified:

- The need for proper planning and preparedness
- The need for prompt and effective action to combat a virus
- Scientific and technical advice
- Vulnerabilities and inequalities
- Government decision-making
- Public health communications
- Legislation and enforcement
- Intergovernmental working.

Specific recommendations

In addition to identifying 10 lessons to inform the planning for and response to a pandemic, a comprehensive description of all the Module recommendations can be found in the full Module 2, 2A, 2B, 2C Report. These are designed to work together with the recommendations from the Inquiry's Module 1 Report, to better safeguard the UK in any future pandemic.

The recommendations include:

- Improving consideration of the impact that decisions might have on those most at risk in an emergency: changes should aim to identify any risks to vulnerable groups, in both the planning for and response to emergencies
- Broadening participation in SAGE (the Scientific Advisory Group for Emergencies), through open recruitment of experts and representation of devolved administrations
- Reforming and clarifying the structures for decision-making during emergencies within each nation
- Ensuring that decisions and their implications are clearly communicated to the public. Laws and guidance should be easily understood and available in accessible formats
- Enabling greater parliamentary scrutiny of the use of emergency powers through safeguards such as time limits and regular reporting on how powers have been used
- Establishing structures to improve the communication between the four nations during an emergency to ensure better alignment of policies where desirable and to provide a clear rationale for differences in approach where necessary.

Module 9 – Economic response

Following this, the public hearings will resume for Module 9 (Economic Response) on 24th November 2025.

Module 10 - Impact on society

A preliminary hearing for the Inquiry's final investigation into the impact of the pandemic on society (Module 10) will take place on 4th November. Public hearings, where the Chair will hear evidence, will begin on 18th February 2026 and end on 5th March 2026.

During the preliminary hearing, Counsel to the Inquiry will provide an update on the investigation's evidence gathering process and preparations for the substantive hearing. Core Participants will have the opportunity to make submissions on matters such as the key issues to be explored and the approach to the investigation.

Module 10's scope includes the impact of the pandemic on:

- the bereaved and bereavement support
- the hospitality, retail, travel and tourism industries
- vulnerable people, including those who faced domestic abuse, homelessness, were within the immigration and asylum system, were in prison or other places of detention and those who were affected by the operation of the justice system
- adult mental health and wellbeing
- key workers, excluding health and social care workers, but including those working in the police service, fire and rescue workers, teachers, cleaners, transport workers, taxi and delivery drivers, funeral workers, security guards and public facing sales and retail workers.

8.2 THIRLWALL INQUIRY

Lady Justice Thirlwall, the Chair of the Thirlwall Inquiry drew all evidence and submissions in the Inquiry to a close on 19th March 2025.

The Chair, Lady Justice Thirlwall, is expected to send out warning letters from September 2025 and the final report will be completed by the end of November. The final report is expected in early 2026.

9. BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this paper as it is for information only.

Resources for progressing the work around any regulatory body reviews lie with the relevant directorate, division, or department as part of business-as-usual functions.

10. EQUALITY AND DIVERSITY IMPLICATIONS

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

However, Equality and Diversity compliance should be considered when implementing changes to processes and procedures in line with the requirements of regulatory body reviews.

APPENDICES

APPENDIX 1 – INTERNAL AUDIT – OPEN 'UNSATISFACTORY' ASSURANCE RECOMMENDATIONS

APPENDIX 2 – INTERNAL AUDIT – OPEN 'LIMITED' ASSURANCE RECOMMENDATIONS

APPENDIX 3 – INTERNAL AUDIT – RECOMMENDATIONS APPROVED FOR CLOSURE - SUMMARY

APPENDIX 4 – AUDIT WALES – OPEN RECOMMENDATIONS

APPENDIX 5 – AUDIT WALES – CLOSURE SUMMARY

APPENDIX 6 – POLICY MANAGEMENT – ALL OVERDUE POLICIES

APPENDIX 7 – MINISTERIAL DIRECTIONS

APPENDIX 8 – WELSH HEALTH CIRCULARS

OPEN 'UNSATISFACTORY' AUDIT RECOMMENDATIONS

ID	Report Title	Year	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Revised implementation date	Number of Revisions	Latest update
0457	Operating Model	2024	High	Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	The Health Board reviews its Governance and Accountability Framework to ensure it provides the necessary scrutiny and assurance from Ward to Board and vice versa.	As part of the organisational structure review, all accountability frameworks will be reviewed	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2026	2	Approved at Audit Committee to change the date as any change to the operating model will replace this version.
1431	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.1 **Medical Resourcing** Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.	2.1 Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			Roadshows on hold until Job Planning policy/Good practice guide shared
1432	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.2 **Medical Resourcing** Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.	2.2 Establish clear communication channels for escalating job planning concerns or discrepancies.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			IHC meetings identifying discrepenacy but without All Wales guidance individual decisions only rather than pan HB guidance

1435	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.1 **Business Continuity** The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in	4.1 The system is web based so accessible anywhere and backup by Allocate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			Business Impact Document in first draft, awaiting review from the BC team
1436	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.2 **Business Continuity** The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in	4.2 Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			The dashboard has been reviewed and agreed in principle, with some minor tweaks required. Access for relevant colleagues is being progressed. A draft SOP is awaiting review to support training and implementation. Please note the revised implementation date.
1437	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.3 **Business Continuity** The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in	4.3 Automate data entry processes wherever possible to reduce human error in transferring information to ESR.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			The dashboard has been reviewed and agreed in principle, with some minor tweaks required. Work is ongoing to ensure the business continuity elements are covered and workforce teams support where possible, a manual feed is taken for e-job plan and shared with workforce intelligence team on a weekly basis
1551	Waiting List Initiative payments – IHC Centre	2025	High	Objective 1: There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales.	1. **Health Board Procedure** The Health Board has no Procedure detailing the planning, authorising, recording and monitoring of Waiting List Initiative (WLI) work in relation to medical and dental staff. We have noted Cardiff and Vale University Health Board have published a dedicated procedure that could be used as a template for developing one in the Health Board (Reference: Waiting List Initiative Procedure - Medical & Dental Staff UHB 515).	1. The Health Board develop, in partnership, and ratify a Waiting List Initiative Procedure to ensure Waiting List Initiative sessions are applied consistently and subject to effective scrutiny and approval across the Health Board, eliminating any inconsistent practice that may be in place with localised, undocumented procedures. The Central IHC, on behalf of the Chief Operating Officer, will lead the development of a BCUHB Waiting List Initiative Procedure.	Tehmeena Ajmal, Chief Operating Officer	31/07/2025	31/12/2025	1	The IAST and EqIA have been approved and the draft procedure is currently being written and as noted in the 15.08.25 update, will require the procedure to be approved through the various committees, the document will then need to go through a consultation period. The implementation date has been revised to 31/12/25 which is being worked to.

1570	Effective Governance - Cancer Services	2025	High	Objective 3: The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt.	3. **Clinical Audit** Management advised that due to absence of Clinical Director, the service is not progressing or monitoring tier 2/3 clinical audits. A gap is identified and will therefore be reviewed by the SLT during 25/26.	3. Level 3 audits within radiotherapy are in their infancy and this is a piece of work that we are addressing following the HIW visit. We have asked an SAS Dr to support the mortality reviews with the Clinical Lead for Radiotherapy which addresses in part level 2 audits. Cancer SLT have also fed back that the Health Board needs to invest in a Chief Clinical Information Officer. Oncology is currently reliant on locum and agency medics who have no SPAs in their job plans only DCCs resulting in limited capacity. The clinical Leads will focus on creating roles with Clinical Audit responsibilities within Consultant Job Plans as we continue to recruit into vacancies on a substantive basis.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			Clinical Strategy continues to be on target. Successful awayday with Senior Doctors held on the 23rd September with a similar event with nursing and AHP colleagues to be held on the 20th October
1613	Effective Governance – Integrated Health Community - East	2025	High	Objective 3: The IHC is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt.	4. **Clinical Audit** Tier 1 audits are reported via the East Clinical Effectiveness Group; however we were not able to evidence this. We are advised that Tier 2 and 3 audits are not regularly monitored or reviewed, therefore we could not ascertain how lessons learnt are shared throughout the IHC or within the Health Board.	4. Develop implementation plan with owners for monitoring and review.	Tehmeena Ajmal, Chief Operating Officer	30/09/2025			
1643	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 2: Project Performance	1. **Procurement/Contract Strategy** The project is being delivered utilising the JCT Standard Building Contract Without Quantities (2016). To date, the project has experienced significant performance issues, including delays, cost uncertainty, and difficulties in managing scope changes. These issues suggest that the form of contract may not be optimally aligned with the complexity and risk profile of the project. It is acknowledged that as part of original efforts to expedite the project to meet WG expectations it was decided that a JCT Contract without quantities would offer the best solution. The UHB may wish to undertake a formal review of its choice of contract strategy, specifically the suitability of the JCT Standard Building Contract Without Quantities (2016) for complex or evolving project environments. The review could assess whether an alternative form would provide better mechanisms for collaborative risk management, cost control, and programme certainty. The findings of this (and a wider evaluation of the project delivery would help mitigate these issues on future projects.	1. Each specific project within the annual Capital Programme shall be subject to a documented delivery strategy including the project specifics, phasing/decant plan, design strategy, procurement strategy, risk management strategy and shall be used as part of the contract selection criteria. The strategy for each project shall be presented to the Director of Environment and Estates for agreement prior to inclusion in the business case. This shall be part of the business case (Commercial Case) and shall document the contract adopted and the benefits and risks. The approach undertaken with regards to Llandudno will not be progressed for future developments, with contracts awarded based on financial ceilings. *LOH: Contract executed so limited opportunity to change other than specific terms and such is unlikely to be accepted by the contractor.*	Russell Caldicott, Executive Director of Finance	31/10/2025			

1644	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 2: Project Performance	2. **Design delays** Prior to going out to tender the UHB engaged a design team to achieve a RIBA Stage 4 level of design to ensure that wherever possible the contractor had sufficient design information during the tender stage to provide a full cost assessment. However noting the nature of the project, it was agreed that a level of further design work would be required by the successful contractor for the project to proceed. When the Works packages were assigned to the successful bidders the UHB design team were not novated across to the appointed contractor who wished to engage their own Mechanical & Engineering (M&E) design team. It is understood however that the UHB has maintained the services of their design team to provide support during the project. The Project to date has suffered from significant delays, some of which are attributable to design considerations, of note are the following extracts from update reports (Highlight reports and Project Manager's Reports for February and March 2025), showing a timeline of design delay issues: • The WS4 (design) submission received in February (2025) was incomplete. The contractor	2. The design strategy included in Action 1 above will be used to assess the core packages to be employer or contractor designed and include: 1. Who undertake what design packages. 2. The design stages. 3. Design transfer/novation arrangements. 4. Design warranty or professional indemnity arrangements. 5. Roles and responsibilities under the contract and for the retained team. 6. Coordination and technical submission arrangements and design variance obligations/restrictions. The criteria may vary according to the specific project. Each project shall, at the earliest opportunity, include an integrated programme for all stages to post-occupation evaluation to the design strategy. The design development, programme and risks shall be reviewed monthly and reported with escalation and mitigation. *LOH: Continue to report and review monthly with escalations and mitigations.*	Russell Caldicott, Executive Director of Finance	31/08/2025			
1649	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Medium	Objective 4: Financial Management	7. **Capital Projects Manual** The Capital Projects Manual and its Addendum were last updated in December 2020 (Version 11). Since then, several changes have occurred that are not incorporated into the current version. As a key resource for managing capital expenditure, the manual should reflect the most current guidance and requirements to remain an effective and relevant reference tool.	7. The current Capital Projects Manual shall be reviewed by the Director of Environment and Estates in conjunction with the Health Boards Capital Accountant	Russell Caldicott, Executive Director of Finance	31/03/2026			Director of Estates and environment will be undertaking this work in Q3

1652	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 6: Site Progress	10. **Inspecting Regime RIBA Stage 5** The RIBA 2020 Plan of Work notes that "It is crucial that it is clear who is to inspect Construction Quality, so that the client can be sure the building will be delivered in line with the requirements of the Building Contract". As this is a JCT contract, the organisation opted to fulfil the traditional Clerk of Works function using internal staff. Two specialist roles were assigned to cover Electrical and Mechanical & Engineering aspects of the project. However, it was noted that there is an assurance gap relating to the inspection of the general construction elements of the build. The RIBA Plan of Work 2020 recommends *that inspections should be carried out by individuals with experience in similar construction technologies.* The absence of dedicated oversight in this area raises concerns regarding the adequacy of assurance over the broader construction works.	10. When a NEC suite contract is used, there is a contractual requirement for the use of Supervisors to routinely inspect and report upon the works. When a JCT suite contract is used, BCUHB shall appoint equivalent appointments for Clerk of Works to inspect and report upon the works. Both approaches provide assurance relating to the works with the reports passed to the Project Manager for inclusion in the monthly progress report. *LOH: The appointment of a building Clerk of Works in unlikely to benefit the scheme at this stage. However, BCUHB to request the architect undertakes site inspections and reports on compliance with their design. M&E inspections to continue.*	Russell Caldicott, Executive Director of Finance	30/09/2025			
1653	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Medium	Objective 6: Site Progress	11. **Inspection restrictions** It was noted from conversations with the respective Clerks of Works that they did not enjoy unfettered access to the site as they were not in possession of the appropriate Construction Site Safety Certification (CSCS) to allow unaccompanied visits. As a result, visits now depend on the availability of the main contractor, with Clerk of Works personnel requiring accompaniment by main contractor employees.	11. BCUHB staff responsible for site visits shall be required to attain the appropriate CSCS accreditation commensurate with their role. This shall be deemed an essential qualification to the satisfactory execution of their duties. *LOH: Staff to be requested to obtain CSCS accreditation if their role requires it.*	Russell Caldicott, Executive Director of Finance	31/12/2025			

1654	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 6: Site Progress	12. **Commissioning Programme** The Clerks of Works noted that they had concerns over the programme of commissioning, this view is supported by the latest Project Manager's report which notes under the key risk/issues section that A detailed commissioning programme needs to be developed with input from the BCUHB / NWSSP teams. This needs to demonstrate the interdependency between both the *Main and Enabling Works programmes* . The report provides further background as to the issues and engagement to date. A formal commissioning programme was requested in Contract Administrator's Instruction (CAI) 113 issued on 13th January 2025. The first iteration that was received on 11th February did not provide sufficient detail and this was notified to the contractor, along with examples of commissioning programmes from other projects, to demonstrate the required level of detail. A revised commissioning programme is awaited. Whilst noting the above concerns as raised about commissioning it is understood that the UHB are seeking to condense the commissioning process to achieve a handover of patient areas ahead of the revised completion date. Given difficulties to date this would require careful consideration and	12. At the outset of the project adequate time shall be allowed for commissioning, witnessing and validation according to the specific requirements of the project including the appointment of a Commissioning Manager. *LOH: A commissioning manager has been appointed and integrated programme for agreement and adoption by stakeholders is being developed.*	Russell Caldicott, Executive Director of Finance	31/10/2025			
1668	Consultant Job Planning - Follow-up	2025	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	1. **Health Board Policy** (*finding in original audit report*) The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011. Limited training is provided to all individuals involved in the job plan process. FOLLOW-UP AUDIT REPORT FINDING: The Health Board does not have an agreed Policy/Standard Operating Procedure in place to support management, and consultants fulfil expected compliance with the nationally agreed Consultant Contract. This remains a significant gap in internal control. We are advised that the Health Board has not progressed with its own draft policy/procedure as it waited for nationally developed best practice guidance which has not materialised.	**1. REVISED ACTION IN FOLLOW-UP REPORT:** The final draft of the BCU job planning policy (JPP) (co authored with LNC / BMA) is to be discussed by Executive Medical Director at JLNC meeting on 14 October 2025. It is anticipated that final approval of the JPP will be secured by December 2025. However, this is a re-iteration of current principles and processes and thus implementation can continue as this goes through final sign off. A training needs analysis has identified 3 core staff groups, with trajectory for completion of training: 1. All medical staff in leadership position with operational responsibility will require training against the JPP. Training to be completed for all within 2 months of JPP approval. Training will be delivered as a series of roadshows, which are planned to be delivered jointly by senior medical leaders and LNC colleagues. 2. Operational staff who will be supporting team and individual job plan meetings.	Clara Day, Executive Medical Director	31/05/2026			All Wales guide on hold. Awaiting Job Planning policy/Good practice guide. Training on Allocate for operational teams continueing. Roadshows on hold until All Wales guidance shared Regular IHC discussions occuring. Specialties are being contacted individually to ask what support is needed from the job planning team to achieve compliance requirement figures. Roadshows on hold until All Wales guidance shared

1669	Consultant Job Planning - Follow-up	2025	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	3 **EJob Plan First and second sign-off** *(finding in original audit report)* Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system. **FOLLOW-UP AUDIT REPORT FINDING:** There has been no formal review of first and second sign off within the EJob Plan system. We were advised that Women's Services have undertaken a review of their sign off details but have not corroborated this. Our review of the information has again identified test and generic details in the system that compromises data quality. Only the training module should be used for test data to preserve the integrity of the live system.	**3 REVISED ACTION IN FOLLOW-UP REPORT:** Process for sign off included in policy, including timeframes for sign off at each stage. The training programs will ensure staff are aware of the process and time to sign off for each stage. A previous 'distant' sign off process has been approved by Local Negotiating Committee (LNC) and will continue within the revised JPP. However, Allocate does not currently facilitate 'distant' sign off. Health Medics team in discussion to ensure this is possible and that any test data is removed from live system. We currently have not received a timeframe for an upgrade of Allocate to facilitate this process. If Allocate are unable to provide the Health Board will need to find a 'work around' which would be in place within 6 months i.e., April 2026.	Clara Day, Executive Medical Director	30/04/2026			Historic sign off SOP in place while waiting All Wales guidance Roadshows on hold until Job Planning policy/Good practice guide shared
1670	Consultant Job Planning - Follow-up	2025	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner	5. **Job Plan annual review** *(finding in original audit report)* Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data. The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work. FOLLOW-UP AUDIT REPORT FINDING: Our review of Health Board data as of 1 September 2025 showed overall compliance of 42% (Image 1 above) where job plans have been agreed and signed off. We have been advised that review dates have not been amended to reflect the individual's incremental date. It remains unclear how the Health Board will meet the 90% target of in-date job plans by 30 September 2025, set by Welsh Government.	5 **REVISED ACTION IN FOLLOW-UP REPORT:** All Wales medical T&Cs advise that all relevant staff should have an in date and signed off job plan at least annually, with updated job plans if there is any significant change to the doctors working pattern or responsibility. This is clearly outlined in the draft policy. It will mean that job plans may not align to the doctor's incremental date. It is also anticipated that any change in operational structure recommended by Foundations for the Future cultural review may impact a number of individual job plan reviews. Monitoring via Power BI in place and allows for drill down by team (but not to individual staff level). The Health Board acknowledges that the target of 90% by September 2025 has not been met. This is primarily due to the delay with agreeing a revised JPP. The proposed trajectory for compliance is 50% end Q3, 75% end Q4, >90% by end Q1. This trajectory will be signed off at the Medical Workforce Group 15 October 2025 Monitoring of compliance would be as above, via local processes and at HB level	Clara Day, Executive Medical Director	30/10/2025			The dashboard has been reviewed and agreed in principle, with some minor tweaks required. Access for relevant colleagues is being progressed. A draft SOP is awaiting review to support training and implementation. Please note the revised implementation date. Compliance observed via Power BI in place, Job Planning compliance has increased from 22% January 2025 to 40% September 2025. No update as awaiting All Wales/Job Planning policy/Good practice guide

1671	Consultant Job Planning - Follow-up	2025	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner	6 **Directorate/Specialty objectives are explicit** *(finding in original audit report)* There is a generic statement within the Service Outcomes section of job plans "To ensure service and jobplan aligned to deliver CPG and wider BCU Strategic direction", (sic). The Service Outcomes section overall was either incomplete or noted "During job plan discussions need to review this". From our review, we are unclear how management are approving job plans without expected service objectives. We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system. FOLLOW-UP AUDIT REPORT FINDING: We reviewed a sample of one job plan from the three Integrated Health Communities and the four pan North Wales clinical directorates. We found four (57%) were in date and current, however none had any directorate or specialty service objectives recorded.	6 **REVISED ACTION IN FOLLOW-UP REPORT:** The draft JPP outlines importance of service demand / capacity discussion prior to an individual job plan timetabling meeting. This will identify service priorities to align at job plan meeting. Individuals PDP from appraisals will inform service and personal priorities and objective for the coming year. The need for service priorities to be clearly articulated and aligned within individual job plans will be a core expectation for the training program and roadshows. Compliance with this element will need to be monitored via a quality assurance process which is beyond current capability of PowerBI monitoring. A sustainable automated solution will be in place within 6 months if DDaT colleagues have the capacity to prioritise this work It is anticipated that implementation of any operational structure following Foundations for the Future review may impact on a need to review service priorities and alignments.	Clara Day, Executive Medical Director	30/04/2026			Ongoing work to upload dept outcomes and priorities as job plans occur - discussed at IHC meeting
1672	Consultant Job Planning - Follow-up	2025	High	Objective 4: Completed job plans reconcile to system records and session payments are correct	8. **Regular review of payments to agreed job plan commitments** *(finding in original audit report)* We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan. We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual reviewor simply roll-over. The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan. FOLLOW-UP AUDIT REPORT FINDING: The Medical Dental and Elements pay report has not been developed for use across the Health Board. We have been advised a dashboard has been produced in conjunction with the Office of the Medical Director (OMD), Surgical IHC West, Finance and People Services. We are advised a meeting was held on 19 August 2025 with a further meeting scheduled for 25 September 2025 but have not corroborated this or requested sight	8 **REVISED ACTION IN FOLLOW-UP REPORT**: Allocate is now linked to ESR to ensure sessions agreed reflect payment. An SOP to ensure implemented will be linked to policy and will be in place by December 2025.	Clara Day, Executive Medical Director	31/12/2025			The dashboard has been reviewed and agreed in principle, with some minor tweaks required. Access for relevant colleagues is being progressed. A draft SOP is awaiting review to support training and implementation. Please note the revised implementation date.

1673	Consultant Job Planning - Follow-up	2025	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	10. **Medical and Dental Job Plan reporting** *(finding in original audit report)* There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance. FOLLOW-UP AUDIT REPORT FINDING: The OMD Job Planning team send out a monthly Job Planning Compliance email that includes a link for the job planning dashboard to a pre-determined circulation. We are unclear whether this circulation captures all relevant leads with responsibility/accountability for job plan compliance. We contacted the seven clinical service Directors to obtain details of their People and Culture meeting or to confirm where job plan performance and assurance was discussed. We received a reply for Centre, East and West IHCs and Women's Services but received no reply from Mental Health and Learning Disabilities, North Wales Managed Clinical Services or Cancer Services.	10 **REVISED ACTION IN FOLLOW-UP REPORT:** Monthly compliance figures are circulated to operational teams and the divisional and IHC medical leaders. It is tracked at Medical Workforce Group at Health Board Level. A compliance escalation and dissemination pathway will be in presented for sign off at November's Medical Workforce Group to ensure clarity on information sharing and scrutiny. An assurance mechanism will be in place by the end of Quarter 4 Real time data is accessible via Allocate. How to access will form part of the Allocate 'how to' training.	Clara Day, Executive Medical Director	31/03/2026			Compliance report updated twice a week, and specialty managers and clinical managers are emailed the link to report in column W
1674	Consultant Job Planning - Follow-up	2025	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	11. **Medical Workforce Group & People & Culture Executive Delivery Group (EDG)** *(finding in original audit report)* The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it "….will receive regular reports (on job plans) as per its Cycle of Business" but we have been unable to verify they have actually received any reports for assurance recently. Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024). The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board. FOLLOW-UP AUDIT REPORT FINDING: There is no evident reporting on consultant job plan performance to the Health Board's People and Culture Committee through the People Operations Report. We note a verbal update was provided to the Committee by the Interim Executive Medical Director at the 14 August 2025 meeting (Agenda Item PC25/82).	11 **REVISED ACTION IN FOLLOW-UP REPORT:** Medical Workforce Group (MWG) is now chaired by an experienced medical leader who has developed Health Board Job Planning Policy in collaboration with LNC. It is the place where relevant care groups are held to account and where implementation of JP policy and relevant procedures will be monitored. MWG will report to People and Culture Executive Delivery Group and thus to People and Culture Committee	Clara Day, Executive Medical Director	31/10/2025			Medical Workforce ToR & minutes submitted as supporting evidence. The P&C EDG has not yet recommenced. Compliance is now reported at MWG and update going to PCC in absence of reestablishment of P&C EDG. Whilst the re-establishment of the People & Culture EDG is under review, regular reporting on medical and dental job planning is received by the People & Culture Committee.

OPEN 'LIMITED' ASSURANCE RECOMMENDATIONS

ID	Report Title	Year	Overall Report rating - from Jan 2025	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Revised implementation date	Number of Revisions	Latest update
0488	Health and Safety - 2024	2024	n/a	High	Matter Arising 1: Policies & Procedures (Operation)	1.1b: Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board	1.1b: The Chief Executive is the responsible Executive Lead until there is a substantive appointment to the Director of Environment post.	Carol Shillabeer, Chief Executive	Immediately			Occupational health and safety is now aligned to the Executive Director of Workforce and Organisational Development rather than the Director of Environment and Estates
0491	Health and Safety - 2024	2024	n/a	Medium pre 01/10/2024	Matter Arising 3: Health & Safety Training (Operation)	3.1a : The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: "the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007".	3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance	Stuart Keen, Director of Environment and Estates	01/09/2024			Email sent to HSE for a quote to deliver the NEBOSH HSE Certificate in Health and Safety Leadership Excellence at a venue (TBC) in North Wales. Response awaited.
0493	Health and Safety - 2024	2024	n/a	High	Matter Arising 5: Gap analysis (Operation)	5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board	5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024	Stuart Keen, Director of Environment and Estates	30/04/2024			Cohort 1: April - East IHC, Central IHC, West IHC (DGHs only), Environment and Estates, Radiology, and MHLD, took part in the Health and Safety Self Assessment. Work is progressing as set out in the paper to the Executive Committee and presentation given to People and Culture Committee. See attached. Cohort 2 will commence in October – Cancer Services, Womens and Maternity Services, Community Services, Pan Services, Corporate Services, and Primary Care.
1340	Corporate Legislative Compliance - Fire Safety	2024	n/a	High	Matter Arising 1: Governance (Design)	1.1b Fire safety reporting groups and committees should meet at regular intervals as per their agreed terms of refence. Any issues with attendance should be escalated to the relevant director	1.1b Meeting to take place in accordance with the Terms of Reference of the Strategic Occupational Health and Safety Group	Stuart Keen, Director of Environment and Estates	29/10/2024	10/04/2025	1	The Strategic Occupational Health and Safety meetings are conducted as aligned with the ToR and Operational Estates present a AAA report on Fire related items and escalated any items of concern
1341	Corporate Legislative Compliance - Fire Safety	2024	n/a	Medium	Matter Arising 2: Policy for the Management of Fire Safety (Design)	2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy	2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.	Stuart Keen, Director of Environment and Estates	20/03/2025			Fire Safety Policy gone through evaluation and awaiting final approval
1343	Corporate Legislative Compliance - Fire Safety	2024	n/a	High	Matter Arising 4: Fire Training (Operation)	4.1a The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.	4.1a Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly. Training needs analysis will be reviewed against the new HTM o5-03 Part A	Stuart Keen, Director of Environment and Estates	20/03/2025			Training will be reviewed following the introduction of the updated WHTM 05-03 Part A.
1445	Consultant Job Planning	2024	n/a	Medium	Objective 4: Completed job plans reconcile to system records and session payments are correct	9. **Additional sessions undertaken outside of the substantive post** We found instances where some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan – This could lead to a Working Time Directive	9. IHC/Divisions need to have detailed meetings with Consultants to breakdown the job plan, to identify what sessions are additional and justification of still being required to be completed.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			On going work focusing on high session job plans

1524	Clinical Audit - 2025	2025	Limited	Medium	Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	3. Overdue Service Assessment of Compliance proformas We were unable to observe evidence of escalation emails for overdue SAoCs being sent for two of the three overdue audits we sampled.	3. The Clinical Effectiveness Facilitator (CEF) will as part of the SOP ensure the following will be required: (a) Evidence of email escalations to be saved to the project folder by the CEF team and an update of the SOP to ensure this is part of the process (b) Schedule regular departmental audits of project folders to confirm that evidence is there – on quarterly basis to be captured with reports produced (c) Document evidence of escalations in The Audit Management and Tracking (AMaT) to make the process transparent – this will show which areas have not replied and ensure that this information is captured by the CEF and monitored properly or escalated as necessary	Clara Day, Executive Medical Director	01/04/2025	30/06/2025	1	Part of the departmental audit, 1st one ran in July, P/P attached, and 2nd one due to run in October. The results, covering publications from 1st April 2024 – 12th June 2025, show some recovery work is still required, as not all had evidence of these escalation emails in the project folder. Screen grab of slide 8 provided as evidence
1525	Clinical Audit - 2025	2025	Limited	High	Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	4. Escalation process for overdue action plans For Tier 1 audits, when an action becomes overdue, weekly reminder emails are sent to the action owner generated from the AMaT system. If the owner does not respond, there is no escalation process in place to ensure the action is completed.	4. We will develop a process for this, to ensure that moving forward that progress is included with Tier 1 improvement actions and included in the Monthly Assurance report that is sent out to IHCs and Divisions. Need to ensure tighter controls are incorporated in our SOPs and that monitored on regular basis to raise and escalate with actions that are overdue	Clara Day, Executive Medical Director	01/04/2025	30/06/2025	1	Ongoing and being tracked by the manager as part of our action plan. Team review we discussed a process for “Overdue Tier 1 actions” looking to get something drafted by 31st October that will be in addition to the reminders sent through AMaT.
1526	Clinical Audit - 2025	2025	Limited	High	Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	5. Lessons learnt shared to appropriate forum We have not been able to demonstrate oversight in collecting data on lessons learned/shared and in developing action plans to address issues from Tier 2 audits.	5. Tier 2 audit details have been captured through Strategic CEG updates and within quarterly reports, however going forward there needs to be a more robust process, similar to Tier 1 and Tier 3. A form will be development to roll out from April 2025 to capture learning, where shared and development of actions plans.	Clara Day, Executive Medical Director	01/04/2025	30/06/2025	1	Ongoing and being tracked by the manager as part of our action plan. Lessons learnt is a section on the SAoC for Tier 1s, a summary of each of these is included in our quarterly report and the team are starting to categorise the information from SAoCs to help identify any themes that spread across the different projects to start to include in our reporting. The new process for Tier 2 audits will now include the completion of an SAoC for these projects, which asks about lessons learnt and will follow the same process
1527	Clinical Audit - 2025	2025	Limited	High	Objective 5: Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed	6. Overdue Tier 3 audits A large number of Tier 3 audits (183) are overdue with no revised dates of completion. We recognise the clinical effectiveness team have introduced a process to improve completion rates, however Integrated Health Communities (IHCs) and Services are responsible for monitoring their Tier 3 audits, and ensuring the E-tool system is up to date with expected time scales.	6. Prior to the internal audit, we had already development and were getting these steps in place: The Clinical Effectiveness Department emails auditors that have overdue projects, to ask them to update the e-tool (either with an updated completion date, mark as complete by uploading report or mark as abandoned). This has been agreed within the team that once this has been requested 3 times non-progress will be reported through departmental Clinical Effectiveness NICE/Audit Group (CENAG) and will then be raised within IHC/Divisions/Services	Clara Day, Executive Medical Director	01/04/2025	30/06/2025	1	Process attached that is followed and below is a summary of where we now stand with Tier 3 from 2024/25 Tier 3 - follow up of open & overdue audits (2024/25 activity) As of 31st March 2025, position was Open: - 72.9% (n=326) Overdue: - 56.6% (n=253) As of 17th Sep, 704 follow up emails have been sent to the project leads and the position for 2024/25 projects stands at: Open: - 16.3% (n=77) - down by 56.6% (n=253) Overdue: - 8.3% (n=37) - down by 48.3% (n=216) NB – a large proportion of these were automatically moved to withdrawn due to non response to the 3 reminder emails sent as
1532	Board Assurance Framework and Risk Management	2025	Reasonable	HIgh	Objective 5: There is targeted risk management training available to staff throughout the Health Board, with completion / compliance monitored.	1. No level 1 mandatory training taking place but note an e learning video has been created and is awaiting upload. We are unable to determine the number of staff who require Level 2 and/or Level 3 training versus those who have received the training. Not all Health Board Members and regular attendees attended the training session on risk management.	1. A new risk management system is being procured, and this will be able to demonstrate all handlers and owners (level 2) requiring training. This will be in place Feb 2026. However, training compliance figures for Level 1 and Level 3 will be shared with the Executive Committee, Directorate, and Divisions, with the support of the Corporate Risk Team. This will facilitate a Health Board-wide approach and ensure commitment	Pam Wenger, Director of Corporate Governance	01/03/2026			Level 2, handlers and owners are updated consistently in the training log as BAU, this compliance is now 76%.This part of the recommendation is complete. The starters and leavers for better tracking of who needs to be trained in Level 3 has now been obtained, the training log can now be updated to better reflect those requiring training, this is only 23% compliannt for level 3 training. The log requires final checking by HoR before this action can be closed.

1534	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	1. Process Management	1.1: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1: The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is	Carol Shillabeer, Chief Executive	30/06/2025			The Director of Performance and Commissioning has been off sick for 2 months (August & September) and retired on 30.09.2025. The CAF has not been progressed as quickly as one would like in his absence. The Deputy Director of Performance has now been tasked with these actions and will have a Draft CAF ready for consideration by HB in January 2026.
1535	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	2. Contractual Obligations	2.1: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1: The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings.	Carol Shillabeer, Chief Executive	30/06/2025			The Director of Performance and Commissioning has been off sick for 2 months (August & September) and retired on 30.09.2025. The CAF has not been progressed as quickly as one would like in his absence. The Deputy Director of Performance has now been tasked with these actions and will have a Draft CAF ready for consideration by HB in January 2026.
1536	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.1: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1: For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements.	Angela Wood, Executive Director of Nursing and Midwifery	30/06/2025			
1537	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.2: Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	3.2: The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing	Angela Wood, Executive Director of Nursing and Midwifery	30/06/2025			This falls within the review of the Integrated Performance Framework and will be completed by January 2026, as per the issues raised in ID 1534.
1538	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	4. Board Assurance	Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1: The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF.	Angela Wood, Executive Director of Nursing and Midwifery	30/06/2025			Contracted Activity is now included in the IQPR but requires further intelligence to accompany the data. The Performance Directorate is working on this and will have a more appropriate reort ready for January 2026.
1552	Waiting List Initiative payments – IHC Centre	2025	Limited	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.1 **WLI Payments** We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time.	**Action 1**. The procedure (above) and agreement of WLI sessions /claim forms to include confirmation that WLI activity complies with requirements of the Consultant Contract. This is a field that will be included in the new BCUHB electronic form to be used to monitor WLI compliance.	Tehmeena Ajmal, Chief Operating Officer	31/05/2025	30/09/2025	1	Following the test period, the electronic form has now been updated with the additional questions to confirm that the WLI activity complies with the requirements of the national consultant contract in Wales and also whether the WLI activity will be undertaken in uncontracted time. These questions are mandatory on the online form that have to be completed before it can be submitted.
1553	Waiting List Initiative payments – IHC Centre	2025	Limited	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.2 **WLI Payments** We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time.	**Action 2**. Supported by the agreed management actions following the Consultant Job Planning Internal Audit report in January 2025, we will ensure an improvement to enable completion of annual job plans to 80% within each year and sustain every year thereafter.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026	30/09/2025	1	Following the test period, the electronic form has now been updated with the additional questions to confirm that the WLI activity complies with the requirements of the national consultant contract in Wales and also whether the WLI activity will be undertaken in uncontracted time. These questions are mandatory on the online form that have to be completed before it can be submitted.
1554	Waiting List Initiative payments – IHC Centre	2025	Limited	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.3 **WLI Payments** We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time.	**Action 3.** BCUHB must clarify its interpretation of section 2.38 of the contract which states - Such sessions may be undertaken in uncontracted time. This will bring clarity to the process, managers involved and clinicians and standardisation in terms of how this is interpreted across specialties. For example, some specialities / IHC interpret uncontracted sessions to include SPA while others do not, as revealed in this audit.	Tehmeena Ajmal, Chief Operating Officer	31/06/2025			

1555	Waiting List Initiative payments – IHC Centre	2025	Limited	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.4 **WLI Payments** We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time.	**Action 4**. Whilst the procedure is under development, additional controls will be implemented to ensure agreed WLI activity is undertaken in uncontracted time noting the need for clarification from action 3. The new electronic form will capture confirmation that the activity is being performed in uncontracted time which will be audited by operational and medical leadership teams.	Tehmeena Ajmal, Chief Operating Officer	31/05/2025			Following the test period, the electronic form has now been updated with the additional questions to confirm that the WLI activity complies with the requirements of the national consultant contract in Wales and also whether the WLI activity will be undertaken in uncontracted time. These questions are mandatory on the online form that have to be completed before it can be submitted.
1558	Partnerships, Engagement and Communication	2025	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	3.1 **Staff resources** We reviewed the evidence provided and found the following issues and limitations: • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via	3.1 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice. Key Deliverables: 1. **Develop and implement a standard operating procedure (SOP)** that outlines: • The Health Board's expectations for engagement. • Required steps and responsibilities at each stage of the process. • Links to national guidance (e.g. WG guidance on service change). • Monitoring, assurance, and reporting requirements.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	31/12/2025	1	The toolkit was discussed at SPSC Group and also the Task and Finish Engagement Group .There is further work to do on refining and testing the toolkit, which will ultimately be combined with a new service change protocol (planning). New revised deadline of end of December 2025.
1561	Partnerships, Engagement and Communication	2025	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	3.4 **Staff resources** We reviewed the evidence provided and found the following issues and limitations: • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via	3.4 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice. Key Deliverables: 4. **Restore access to all key documents referenced**: • Upload the Welsh Government Guidance on Service Change and the Key Lines of Enquiry Framework to BetsiNet. • Ensure all links are checked quarterly for functionality.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	31/12/2025	1	Will be complete when the toolkit is signed off. New delivery date end December 2025.

1569	Effective Governance - Cancer Services	2025	Limited	High	Objective 2: There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	2. **Delivering financial balance** There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target.	2. The division took further actions in respect of grip and control of expenditure, with cost reductions & control actions aligned to the control total target issued by the health board being met and exceeded. Further action re delivery of CRES savings resulting achieving an over recovery of targets of £2k. However, it is recognised that a final £1m deficit remains against budget allocated and therefore non-compliant with requirements of Standing Financial Instruction 5.2.2 The overspend is represented by Drug related expenditure and commissioning contracts aligned to demonstratable growth. These issues have been escalated & reported through the health board and the various committees such as Execs & PFIG. Actions • An Oncology business case has been presented with final approval at board pending May 25 to secure recurrent budget. A further business case is ongoing to address further cost pressures linked to demand, activity, quality & governance pan BCU. • Ensure working focus groups such as SACT improvement etc are documented as reports for information or minuted through attendance at PFIG or SLT to demonstrate ongoing improvement for patient safety, quality, efficiencies and finance.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			Monthly PFIG meetings continue with multi-professional oversight of spend and review of any additional funding requests. Weekly establishment control meeting with DGM, HoN, finance and people services to review all roles at DMT stage – only roles that are funded and considered essential are approved All budget holders meet regularly with finance partners to ensure budgets are managed Close partnership with Medicines Management for drug spend and potential savings. SACT drug production has been restricted in the cancer pharmacy units for safety reasons resulting in increased outsourcing of production
1571	Effective Governance - Cancer Services	2025	Limited	High	Objective 4: Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate.	4. **Open / Overdue Incidents** As of March 2025, the service has 195 open incidents, with 154 of these overdue.	4. The number of incidents since March has decreased significantly to 98. This is due to an agreed action of discussing and encouraging the investigating and closing of incidents in a timely manner through discussions at the daily Patient Safety Huddle, weekly e-mail reminders to incident handlers by the Patient Safety team and by further monitoring through the monthly PSQG Meeting.	Tehmeena Ajmal, Chief Operating Officer	31/10/2026			The number of incidents is continuing on a downward trajectory from the 195 open incidents / 154 overdue at the time of audit having reduced to 50 open incidents of which 34 are overdue.
1573	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	Medium	Matter Arising 1: Policy (Design)	1.2 The Head of Corporate Governance will issue a guidance note to all Managers as part of the development of a Corporate Governance Hub.	1.2 Management: • Communicate operational requirements and ensure that relevant staff groups are aware of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving, and escalating issues of concern).	Pam Wenger, Director of Corporate Governance	30/09/2025			Governance Hub populated awaiting sign off for go live - will be continuously updated.
1580	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 5: BCU staff declarations of interest (Operation)	**SAME AS 2.1 (b)** 5.1 (b) Management: • Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).	**SAME AS 2.1 (b)** 5.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			The Workforce team have confirmed that the new PADR forms inlcude reference to Declarations of Interest.
1581	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (a) To undertake specific improvement project looking at the processes at an IHC level in relation to Declaring Gifts and Hospitality . (March 2026)	6.1 (a) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable	Pam Wenger, Director of Corporate Governance	31/03/2026			A Corporate Governance Improvement Plan is being drafted this will be one of the areas of focus

1582	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (b) To establish Governance Network working with operational leads to support the implementation of this work .	6.1 (b) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable	Pam Wenger, Director of Corporate Governance	31/03/2026			A Corporate Governance Improvement Plan is being drafted this will be one of the areas of focus
1587	Grievance Management	2025	Reasonable	High	Objective 5: There is an analysis of grievance cases, including satisfaction and feedback of the employees and managers involved in the process, allowing trends or themes to be identified, follow up action to be monitored and regular sharing of learning.	2. **Themes** Whilst we are advised that grievance cases are reviewed and discussed locally and by the senior team within People Services, there is no documented information / data that identifies themes and trend of grievances across areas / the Health Board, and reports on these to an appropriate forum. This information should be reviewed to ensure appropriate actions are taken to minimise potential future grievances.	2. Quarterly review of closed R&R cases to collect data on the themes / trends, which will be reported via People and Culture meetings / Committee. Local People & OD teams will do this at the end of a case.	Jason Brannan, Deputy Director of People	31/08/2025			A thematic review of R&R cases during the year from 1 September 2024 has been completed. The most prevalent reason for submission of a formal request for resolution is working conditions, working relationships, policy and procedures. A high number of cases are recorded as 'other' so the underlying reason is unclear. A task and finish group is currently reviewing the categorisation for employment relations cases, including the reasons in order to improve the quality of the data.
1588	Grievance Management	2025	Reasonable	Medium	Objective 5: There is an analysis of grievance cases, including satisfaction and feedback of the employees and managers involved in the process, allowing trends or themes to be identified, follow up action to be monitored and regular sharing of learning.	3. **Lessons learnt** The All-Wales policy does not require lessons learnt to be captured, but suggests reflection and learning from the process. We recognise that outcomes and learning from cases is often discussed informally within meetings however it would be beneficial to capture that information and report via the Health Board governance structure to provide assurance that there is learning from grievance cases / actions taken to reduce likelihood of similar grievances being raised.	3. Lessons learned to be reviewed by Employment team / one to one's / Team locally. This will also go to the Executive Team for review and follow up, along with the information relating to delays for escalated cases.	Jason Brannan, Deputy Director of People	31/08/2025			Lessons learnt is being completed at the conclusion of each case. Themes and learning are now reported through the ER Cases report to People and Culture Committee.
1611	Effective Governance – Integrated Health Community - East	2025	Limited	High	Objective 2: There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	2. **Accountability Letters** A number of IHC East accountability letters for 2024/25 have not been signed, as required by Standing Financial Instructions. Out of a total of 89 letters, 73% (65) have been accepted, 23% (20) have had no response and 4% (4) are outstanding with a valid reason noted (not confirmed).	2. Sign accountability letters.	Tehmeena Ajmal, Chief Operating Officer	31/07/2025			
1612	Effective Governance – Integrated Health Community - East	2025	Limited	High	Objective 2: There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	3. **Delivering financial balance** There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target	3. Review forecast year end position with finance team.	Tehmeena Ajmal, Chief Operating Officer	30/09/2025			

1618	Falls Management - Follow up	2025	N/A	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1(a) - Action 2 - **RECOMMENDATION:** Staff should be reminded, through training, of the requirement to ensure the Falls and Bone Health Multifactorial Assessment (FBHMA) and documentation pertaining to patient falls, provides sufficient information to fully understand the patients' needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms. **Current status - Partially implemented** **FINDING** Training data provided by the Ward Accreditation Team shows an upward trend in falls training 1A and 1B over the past year. The Health Board's mandatory Falls Prevention E-learning module 1B, related to the FBHMA, has been updated. Additionally, a "how to" guide has been produced, featuring examples of effective risk assessments for FBHMA and patient handling forms. This guide offers extra clarity and expectations for Agency workers when operating within the Health Board. Progress has been made to enhance the quality of risk assessments through increased monitoring and coaching. This includes the following initiatives: • Embedding the process of monthly Ward	2.1(a) - Action 2 - The West Therapy Team has committed to the following action, with implementation complete by end Q2: The detail regarding the approach to improvement is in the process of being agreed by the Therapy leads. Changes to a patients' function can be documented in the WNCR which the ward would have access to. The leads will make staff aware of the FBHMA domains on the assessment form so they ensure assessment outcomes can be correctly communicated to the ward in the WNCR and board rounds in FBHMA terms.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025	30/11/2025	1	Most ward managers in Glan Clwyd Hospital have read-only access to Therapy Manager and can view the therapists' documentation. We have extended access to all ward managers and/or falls champions in Glan Clwyd hospital and all community hospitals. Therapists are also present daily on the wards and attend board rounds. Pertinent information relating to mobility, transfer and function will be shared and communicated at Board Rounds to enable nursing staff to update the FBHMA assessment. We have also reviewed staff compliance with the part B of the falls training which describes completion of the FBHMA via ESR report and send all-user reminders.
1619	Falls Management - Follow up	2025	N/A	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1(b) **RECOMMENDATION** - To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered. **FINDING FOLLOWING FOLLOW-UP REVIEW:** The Welsh Nursing Care Record (WNCR) digital system does not automatically populate patient details, such as mobility status, from the admission assessment section into the FBHMA. This issue affects all of Wales and the project to address it is expected to begin in approximately 18 months. In the meantime, the Health Board is mitigating the risk through control measures outlined in section 2.1a. A review of the questions within the FBHMA and the patient handling form is needed. Some questions, like "Is the patient at risk of falls?" seem repetitive. It may be beneficial to merge the forms or reduce the repetition.	2.1(b) All Wales Falls and Bone Health Multifactorial Assessment (FBHMA). WNCR Team to complete deep dive / audit of 30 patients to review completion and the quality of patient fall documentation –this will be done in July 2025 by the Chief Nursing Information Officer and reported back to the Strategic Falls group in September 2025 for action. Note: There are no formal plans on an All-Wales basis to update the national WNCR system. However, BCUHB will continue to request relevant information is auto populated on a future update.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025	31/10/2025	1	Deep Dive completed. Data being pulled together ready to be presented at the next Strategic Falls Group in October 2025

1620	Falls Management - Follow up	2025	N/A	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1(c) **RECOMMENDATION:** Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms. **FINDING FOLLOWING FOLLOW-UP REVIEW:** The Health Board has created a dashboard to assist the wards in enhancing their quality by tracking the completion of the FBHMA. In addition to the control measures cited with section 2.1a In our sample testing of 36 patients, eight (22%) FBMHAs were found to be outdated due to patient transfers. Reassessment is necessary if the patient's condition or environment changes, or at a minimum, weekly, as specified in section 7.1 of the Falls Policy. Discussions with Ward Managers revealed that the FBMHA currently only triggers as overdue for review after a week has passed, rather than upon patient transfer. Other systems (STREAM, WNCR and Patient Administration System PAS) all capture patient transfer, however the FBMHA assessment is not linked to these to prompt a review of the assessment.	2.1(c) All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) Chief Nursing Information Officer to chase DHCW for a date as to when the request for change to ensure alert to trigger reassessment on transfer will be implemented in WNCR, the request will be made in July 2025 and monitored through the Strategic Falls Group.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025	31/12/2025	1	Update remains as per the previous update. Awaiting the technical prioritisation for WNCR to be undertaken by DHCW
1622	Falls Management - Follow up	2025	N/A	High	Matter Arising 3: Training (Operation and Design)	3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. **Current status – Partially implemented** Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective integration into the role. The Manual Handling team share training rooms with the wider Health and Safety team and the Resuscitation team in the East, impacting the availability of training opportunities. Whilst the use of external facilities for training was	3.1(a) Action 2 - Training There is also a review underway by Manual Handling Manager with Service Leads to ensure those identified on ESR as requiring this training is accurate – Head of Health & Safety (29th August 2025).	Angela Wood, Executive Director of Nursing and Midwifery	29/08/2025	30/11/2025	1	Work continues on the positional numbers. All service managers have been contacted but a number of responses remain outstanding, these will continue to be followed up. Work will begin on updating ESR from responses received to date.

1623	Falls Management - Follow up	2025	N/A	High	Matter Arising 3: Training (Operation and Design)	3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. **Current status – Partially implemented** Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective integration into the role. The Manual Handling team share training rooms with the wider Health and Safety team and the Resuscitation team in the East, impacting the availability of training opportunities. Whilst the use of external facilities for training was	3.1(a) Action 3 - Training Discussions ongoing regarding the upskilling of Manual Handling Champions to support the Corporate Team with local delivery of refresher training, thereby reducing the number of colleagues attending a classroom-based refresher – Head of Health, Safety & Security -October 2025.	Angela Wood, Executive Director of Nursing and Midwifery	30/10/2025			Meeting scheduled with University for 28/10/2025.
1629	Falls Management - Follow up	2025	N/A	High	Matter Arising 4: Governance (Operation)	4.1(a) Action 3: The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls. **Current status - Partially implemented** **Finding** In conjunction with evidence provided within recommendation 4.1b, the Health Board continues to implement a strategy that routinely identifies themes, trends, and lessons learned. The following was provided to evidence this: • A Chair's report from the Health Board Strategic Inpatient Falls group is presented to the Patient Safety Group on a monthly update. • The Strategic Inpatient Falls Prevention Group meet monthly, which is an opportunity to share findings, themes and lessons learned. • Falls are subject to focused review contained within Datix system. • Executive Led Integrated Concerns Oversight Panels are in place; previously Rapid Learning Panels, to gain assurance that reviews of serious incidents are taking place to identify learning and immediate actions. • Rapid Review of complaints and incidents - we were provided with a document used by staff involved to identify immediate issues and learning following an incident. This is reviewed by the Corporate Patient Safety Team and submitted	4.1(a) Action 3: Governance When Falls Champions established pan BCUHB, completion of SWARM will also be monitored / audited by Falls Champions (commenced April 2025, implementation December 2025).	Angela Wood, Executive Director of Nursing and Midwifery	31/12/2025			Falls Champion Network meeting Sept/Oct 25 Bedside learning discussed and expectations explained sessions includes having difficult conversations, coaching colleagues. Falls Champions expected to keep a training log for evidence. Accreditation offering support on ward with Falls Champions.

1632	Performance Management Framework and Reporting	2025	Limited	High	Objective 1: There is a governance structure with mechanisms for regular monitoring and escalation in place.	1. **Governance** Through the review of the Executive Delivery Group Minutes and reports received from two IHCs and MHLD we have not been able to confirm that Decision and Action Logs from substructure or Integrated Performance Scorecards feed into the Integrated Performance Executive Delivery Group or that performance translates down to Individual PADRs.	1. The Integrated Performance Framework to be fully implemented during quarter 2 of 2025/26. This will entail monthly meetings with the larger management structures delivering patient care. The reporting hierarchy will ensure “ward to board” assurance reporting.	Russell Caldicott, Executive Director of Finance	30/09/2025			Whilst a governance structure is described in the IPF (a superstructure and substructure) the work to properly align the substructure to the superstructure has not yet begun. This work entails ensuring that service governance structures are aligned with the corporate structure so that perfomance reporting, escalation and accountability can easily flow up and down the organisation's performance governance routes in an appropriate and timely manner. This work has been set aside until the outcome of work on Foundations For the Future is being implemented to ensure the correct aligments across the organisation.
1633	Performance Management Framework and Reporting	2025	Limited	High	Objective 2: There is evidence to support reported performance data and narrative.	2. **Performance** We have been unable to verify the source and rationale underpinning the identification and reporting of local performance metrics that are included in addition to the national measures. Consequently, we are unclear that the highest risk local matters are being reported for scrutiny and assurance.	2. Local performance indicators and escalations are created where a services performance is showing early signs of distress or consistently failing a target. Whilst outside of the NHS Wales performance framework it is essential to identify areas that need further scrutiny and assurance as the NHS Wales performance framework cannot cover all delivery of the NHS. The Performance Team working with the relevant Service Lead, will include the source and rationale underpinning any local metrics.	Russell Caldicott, Executive Director of Finance	30/09/2025			The Local Measures included in the IQPR for HB and its Committees were developed and agreed with the Quality Team and Executive Director of Nursing, the Workforce and Organisational Development Directorate and the Associate Director of Workforce Optimisdation, and the Finance Directorate with the Executive Director of Finance. Further work needs to be undertaken to underpin these metrics, and to identify other relevant metrics that may require escalation to HB. These will be identified through robust implementation of the IPF as it progresses through the various levels of the organisation over the next 18 months.
1634	Performance Management Framework and Reporting	2025	Limited	High	Objective 3: Arrangements are in place within the operational management structure where operational leaders and Executive scrutinise and hold to account areas of poor performance, evidence this and review whether expected remedial action is implemented and improved performance to the service user.	3. **Performance Accountability** Whilst we note executive accountability meetings take place and accountability/service performance reports produced; these are not operating consistently as expected. We were unable to confirm the outcomes of performance meetings as we did not receive any minutes/evidence of specific actions set to address the required improvement in performance.	3. Finding accepted. The Health Board is in the process of setting up monthly meetings with IHCs and pan BCU patient facing services. Initial meetings have been held in quarter 1 with monthly meeting to be diarised during quarter 2 to run monthly from September onwards.	Russell Caldicott, Executive Director of Finance	30/09/2025			Due to the intense focus on planned care, with almost daily meetings, weekly 'must attend meetings', the implementation of the monthly or quarterly Integrated Accountability/ Performance Reviews has not been progressed. The review of the IPF (including CAF) will require the full support of the Executive Team and Corporate Governance Directorate in ensuring that the Reviews, once agreed upon, are set into the corporate calendar, executive cycle of business and managed, resourced and implemented appropriately as outlined in the IPF.
1655	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 7: Equipping	13. **Equipment budget** The Project has an equipment budget of £3.4m and the outturn figure has remained as such despite, the work going on to reuse existing equipment where possible, it would be anticipated that this would feed into projected savings. However, the outturn has instead recently increased by £85k with no narrative explaining the reason for this increase. It is not clear at the present time what the eventual equipment expenditure will be, given the above, and issues over the ordering and supply of equipment, with possible financial and availability ramifications. The ongoing design issues (and absence of formal sign off) could also adversely impact on the final equipment schedules, budget and ultimately the outturn costs.	13. A genuine pre-estimate of equipment and costs shall be undertaken at key stages using the signed-off C-Sheets and Room Data Sheets and if not prepared by the Cost Manager, shall be reviewed by the CM. An audit of the equipment approved as required, equipment ordered and equipment delivered shall be undertaken as appropriate. *LOH: A review to validate the budget cost and equipment required, ordered and delivered was commenced in July 2025. A report will be presented at the August Board.*	Russell Caldicott, Executive Director of Finance	30/09/2025			

1657	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	High	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	2. **Incomplete Plan** Coverage Several departments have not submitted current BCPs and while 47 BCPs are live, a significant number (43) are still awaiting Director sign off. Management is unable to provide completion rates of BCPs at both directorate and Health Board levels - work remains to ensure full coverage across all services. There should be a process to ensure all services within the Health Board have BCPs. The BCPs repository on BetsiNet appeared to hold outdated BCPs, such as the BCP for District Nursing created in 2022.	1) To create a dashboard reporting mechanism to show denominators, % of compliance and the introduction of a RAG system to easily identify high risk areas. 2) To create a mapping template to forward to the IHCs, Pan BCU and Corporate Teams to identify their denominator (ie number of services that require a Business Continuity plan). 3) By way of formal escalation process, to report all compliance from the dashboard summary to the Civil Contingencies Assurance Group (CCAG) quarterly, or upon request identifying areas of non compliance where action is required.	Jane Moore, Executive Director of Public Health	31/12/2025			1) The Business Continuity dashboard has been drafted, a RAG system has been introduced with a % compliance indicator. The denominators (which will inform the % compliance indicator) are still being worked up. The new BC dashboard is being presented to CCAG 30th September for approval. 2) The mapping template has been created and signed off by the Head of EPRR. All BCPs received to date are now inputted and reported via the dashboard. The template will be shared with the IHCs and corporate teams to assist in retrieving a denominator and BC plans. 3) Once fully established and all denominators confirmred, utilising the new BC Dashboard reporting process, quarterly performane and assurance reports will be taken to the Civil Contingencies Assurance Group identifying low and non-comliance services. Monthly BC performance reporting will also be provided to IHCs and corporate teams identifying action required.
1658	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	High	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	3. **Limited Plan Testing** While some exercises have been conducted, most BCPs and incident plans have not been tested. Testing is not yet consistent across all departments. Women's Services exercises are delayed, and exercises for Emergency Departments are still in planning.	1) To draft an options appraisal on how we can best achieve the above. 2)To receive Executive sponsor sign off on the options appraisal, and take though the governance route of CCAG, Executive Committee and PPHP if required. 3)To then action and implement the agreed recommendation/option following governance reviews.	Jane Moore, Executive Director of Public Health	31/12/2025			1) A draft Options Appraisal to support the roll out of Exercise and Testing will be taken to the Civil Contingencies Assurance Group meeting on 30th September. 2) Actions out of the Options Appraisal will be agreed and taken forward
1659	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	Medium	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	4. **Training** A training matrix is in place for Management on Call staff, but not all staff have completed the required training (current completion rate is 71%). We are unsighted on whether training plans are in place for Business Continuity Leads/Champions in areas not impacted by Management on Call e.g., Corporate function continuity plans.	1) To develop an EPRR training programme including front of house clinical/operational response needs and management on call training requirements 2) To create a dashboard by linking in the training compliance matrix already in place to include the total amount of Bronze / Silver / Gold on call colleagues who have completed the EPRR Major Incident training and the denominator. This will also identify those who are yet to attend. 3) To report all compliance from the dashboard summary to the Civil Contingencies Assurance Group (CCAG) quarterly, or upon request.	Jane Moore, Executive Director of Public Health	31/03/2026			1) An EPRR Training Programme is in development - this will support on call training requirements, clinical respone training and training for any other roles identified in incident response (ie Loggists, CBRN/Business Continuity Leads etc). Work has commenced with the x3 ED Clinical Leads to review and re-start clinical major incident training 2) A draft Training dashboard has been developed. This will include all internal and external training attended, % compliance and feedback from training completed. This new dashboard will be presented to CCAG on 30th September 2025. 3) Quarterly EPRR Training performane and assurance reports will be taken to CCAG identifying low and non-comliance. Monthly EPRR training performance reporting will also be provided to IHCs and corporate teams identifying action required.
1660	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	Medium	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	5. **Outdated Policies and Procedures.** Core EPRR policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.	All outstanding EPRR policies, templates, plans, policies and SOPs are agenda for approval/sign off at the next CCAG 30th September 2025.	Jane Moore, Executive Director of Public Health	31/12/2025			1) A paper has been drafted and is going to the Civil Contingencies Assurance Group meeting on 30th september for approval.

1678	Digital Benefits and Change	2025	Reasonable	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.1 **Benefits Reporting** Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital	2.1 Agree benefits reporting and escalation structure within the Digital Data and Technology (DDaT) Team.	Dylan Roberts, Chief Digital and Information Officer	31/12/2025			
1679	Digital Benefits and Change	2025	Reasonable	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.2 **Benefits Reporting** Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital	2.2 Agree benefits reporting structure with the Executive Team to demonstrate the value of projects across various BCUHB governance groups outside of the DDaT Team.	Dylan Roberts, Chief Digital and Information Officer	31/03/2026			
1680	Digital Benefits and Change	2025	Reasonable	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.3 **Benefits Reporting** Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital	2.3 Review the Benefits Framework to include updated reporting and escalation routes.	Dylan Roberts, Chief Digital and Information Officer	31/03/2026			

SUMMARY OF INTERNAL AUDIT RECOMMENDATIONS APPROVED FOR CLOSURE BY EXECUTIVE COMMITTEE

			Summary of recommendation with rationale for closure
EXECUTIVE DIRECTOR OF NURSING			
1	0298	Falls Management	Patient Handling Training forms part of the mandatory training identified for all staff at the Health Board with more in-depth training i.e. level 2 for identified clinical / patient facing staff. Overall compliance for the Health Board for mandatory training is monitored and reported at various meetings with specific focus on patient safety training via the Patient Safety Group and Executive Quality Delivery Group. Mandatory training will continue to be monitored and reported. Given the size of the Health Board and variable changing influences 100% compliance will not be reached and maintained. Therefore the target is 85%, overall compliance has remained above the target for the last 12 months. The Manual Handling Team are proactively planning ahead with the successful tender to deliver manual handling level 2 training to students to enable continuity of training and assurance that students are trained to the right level prior to commencing their placement within BCUHB.
2	1598	Duty of Quality	The policy has been ratified by the Health Board and is now available across the organisation.
3	1599		Training needs analysis undertaken.
4	1617	Falls Management - Follow up	The Central Therapy Team are now also adhering to the FBHMA assessment processes in line wtih the East IHC. Access to the Therapy Manager has been extended to all ward managers and/or falls champions in Glan Clwyd hospital and all community hospitals. Therapists are also present daily on the wards and attend board rounds. Pertinent information relating to mobility, transfer and function will be shared and communicated at Board Rounds to enable nursing staff to update the FBHMA assessment. Staff compliance with part B of the falls training is reviewed and all-user reminders are sent.
5	1621		Manual Handling Mandatory Training compliance to be monitored by the Strategic Falls Group. A report is produced by the Manual Handling Manager for the standing item on the agenda.
6	1625		Falls Champions have been identified across inpatient areas and have 4 hours protected time per month to undertake role. The Ward Accreditation team have developed a network and support framework for Falls Champions, including 1:1 support if required in ward environment. Falls Champion network sessions have included training session on Beside learning. The Strategic Falls meeting receive an update report from the Falls Leads for each IHC. This is now via a standardised template and is a standing agenda item.
7	1627		Falls Champion Network meetings for Sept/October across all the Health Board include SWARM document and rationale for using post fall. SWARM document part of the weekly review following a fall uploaded to datix incident reporting system. Matron Monthly metrics continue.
8	1628		Discussed in August Strategic Falls meeting. SWARM document discussed as part of the Falls Champion Network meetings Sept/Oct 25.
CHIEF DIGITAL AND INFORMATION OFFICER (approved for closure by Assistant Director of Compliance and Business Management)			
1	1479	Network and Disaster Recovery	The access group has been reviewed and all non-ICT staff who have no business case have been reviewed. Staff with a valid case, for example Estates have been retained in the group. Screenshot of group membership to be provided for next update.
2	1480		ICT have taken up responsibility for managing access to the relevant door.
3	1481		Reminder sent to all ICT staff
4	1483		Review of CCTV provision has been carried out.
5	1488		An online Critical Infrastructure Hosting Audit Form developed - each facility will be subject to an annual audit by the Cyber Security and Compliance Team. This requirement has been added to the Cyber Security Work Programme.
DIRECTOR OF PARTNERSHIPS, ENGAGEMENT AND COMMUNICATIONS			
1	1556	Partnerships, Engagement and Communication	Consolidated plan complete
2	1559		Two staff engagement workshops have taken place. These have supported the co-design the draft engagement framework and principles and staff shared their ideas on toolkits and training. The engagement intranet section has since been updated to reflect the discussions and work is now underway to develop a Teams channel to support the Staff Engagement Community of Practice.
3	1560		The reference to personal emails was in the Padlet resource document (and a workforce document that is no longer on the resource page). The padlet resource references not using personal emails.
4	1562		Annual check took place in May 2025 and is scheduled for further annual review om May 2026. Named Engagement Officer has been assigned to the review.
5	1563		Teams reflect discussions in notes and each SLT member follow up emails on discussions which reflect progress and escalation.
EXECUTIVE DIRECTOR OF FINANCE			
1	1499	Establishment Control	Final year to date totals were reported in May 2025 in IPEDG. The signed Accountability Agreements remain at; 90% signed off 8% remain outstanding with reasons not explicit It is a key element of the Internal Audit ask to ensure budgets are received and if not endorsed, the reasons clearly articulated. The 25/26 Accountability Agreements will be circulated as soon as the 25/26 budget is finalised.
2	1500		Superceded by audit ID 1596
3	1501		During month 4 all negative whole time equivalents relating to vacancy factors have been removed any negative budgets remaining are as a result of house keeping issues.
4	1546	Standing Financial Instructions - Procurement	No further action required.
5	1549		The revised SoRD was approved by Board on 25 September. The new SoRD includes the introduction of a 'tier' for financial delegations, this is to ensure that there is consistency in terms of the levels of delegations across the organisation.
6	1648	Orthopaedic Surgical Hub Llandudno Hospital - 2025	The revised SFIs and SORD were approved by Board on 25 September 2025
7	1650		Update was shared with PFIG private committee on August 26th 2025.
8	1651		The revised SORD was approved by Board on 25 September 2025

INTERIM EXECUTIVE MEDICAL DIRECTOR AND DEPUTY DIRECTOR OF PEOPLE (approved by Sreeman Andole prior to his departure)			
1	1443	Consultant Job Planning	Board Outcomes have been input into Allocate

CHIEF OPERATING OFFICER			
1	0458	Discharge Arrangements	The BCU Hospital Discharge Policy and Protocol has been approved and published
2	1283	Effective Governance –	Central IHC has completed the review of the governance arrangements including frequency of meetings, ToR and Cycle of Business
3	1285	Integrated Health Community (IHC) Central	The purpose of the Clinical Effectiveness Group (CEG) is to identify clinical risk via oversight and review of the following programs: •National and Local Clinical Audits •NICE Guidance. Providing assurance in relation to improving clinical effectiveness and the safety of patients within the Health Board's services, as well as those provided by other organisations on behalf of the Health Board or as part of a partnership arrangement. CEG will discuss and confirm the level of clinical risk being held, triangulate against risk register and escalate any significant risk to QODG. CEG central will triangulate across directorates to oversee and support the development of IHC wide action/improvement plans to mitigate any clinical risks identified. CEG also ensures clinical and operational teams are aware of all clinical risks, and share improvement / action plans that have been developed across other services and be a point to oversee development of New Ways of Working and act as a point of approval and dissemination for new Policies-Standard Operating Procedures (SOP) process,
4	1286		
5	1568	Effective Governance - Cancer Services	Cancer Pathway Performance dicsussed at Cancer Service Senior Leadership Team meetings. It is noted the improvements for delivering performance on cancer targets is within the responsibility of the IHCs and more detailed discussions are held at the Single Cancer Pathway Delivery Group with IHC leads and wider services.

DIRECTOR OF CORPORATE GOVERNANCE			
1	1574	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	The Declaration of Interest register and information is now linked to our website
2	1576		The Corporate Governance Report, which included the Declarations of Interest updates presented to Audit Committee on 21/10/2025. This will be brought regularly to the Audit Committee Meeting.
3	1577		The Declaration of Interest register and information is now linked to our website
4	1579		The Declaration of Interest register and information is now linked to our website

OPEN EXTERNAL AUDIT RECOMMENDATIONS

ID	Report Title	Year	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Revised implementation date	Number of Revisions	Latest update
0394	Structured Assessment 2022	2023	Recommendation 12: Improve performance and financial oversight for digital and estates	R12b: There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should: • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation.	R12b: Although addressing deficiencies and risks are the priority proof of value, work in small affordable pockets are progressing and demonstrating the benefits that can be delivered if scaled.	Dylan Roberts, Chief Digital and Information Officer	31/12/2023	31/03/2026	2	**(Update on behalf of DDaT only)** Revised bids submitted for short term non-recurrent funding only for Digital Dictation, Digital Priorities, Legacy staffing, Results Management Various ongoing projects (unfunded) e.g. MTED - DDAT, Welsh Community Care Information System (WCCIS) Business Case & STREAM Business Case EHR external support, Clinical and Digital Transformation Office, Critical Technical Capabilities Population Health Management Data Analytics Digital Training Strategy (Digital Academy). Awaiting to hear from Executive Committee still on whether these bids will be successful. Digital Inclusion and Digital Innovation including AI were withdrawn as short term non-recurrent funding would not be appropriate to drive these areas forward, longer term funding would be required. **Implementation date revised to 31/03/2026.**
0399	Structured Assessment 2023	2023	Recommendation tracking	R5a: Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales.	R5a: Agreed. A recent review of all of the Board Committee cycle of business (received at the Board in January 2024) has made some provision for recommendations received by non audit bodies. This includes QSE Committee and a People and Culture Committee.	Pam Wenger, Director of Corporate Governance	31/07/2024	31/03/2026	2	The Compliance Report, presented to both the Executive Committee and Audit Committee, includes a section around regulatory compliance, which is the update provided to QSE. There is a considerable amount of work to be done to put this in place, as it involves others outside the Corporate Governance Directorate, as well as a system to capture the information. This work sits within both the ADP and Corporate Governance Directorate Plan, for completion in Q3 of 2025/26. This is unlikely to be achievable due to the availiabilty of resources to plan and management the process and to develop the system,
0400	Structured Assessment 2023	2023	Recommendation tracking	R5b: Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales.	R5b: The Director of Corporate Governance will put in place a process and system to ensure that recommendations by other bodies are co-ordinate and have appropriate oversight at Committee and where appropriate Board level.	Pam Wenger, Director of Corporate Governance	31/07/2024	31/03/2026	2	The Compliance Report, presented to both the Executive Committee and Audit Committee, includes a section around regulatory compliance, which is the update provided to QSE. There is a considerable amount of work to be done to put this in place, as it involves others outside the Corporate Governance Directorate, as well as a system to capture the information. This work sits within both the ADP and Corporate Governance Directorate Plan, for completion in Q3 of 2025/26. This is unlikely to be achievable due to the availiabilty of resources to plan and management the process and to develop the system,

1364	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Addressing key gaps in capacity	R10. The Health Board and local authorities need to work together to develop joint solutions to address key gaps in service capacity, in particular, domiciliary care and reablement services which would enable timelier discharge of patients to their own home.	**Sub-regional:** Utilise Further Faster Funding and action planning In Central, D2RA team at the front door working as Trusted Assessors to address the gaps in assessment capacity working together with local authorities to support reablement provision ongoing work to support more timely discharge required for POC with agreed Trusted assessment pathways Central Area Integrated Services Board considers the development of joint solutions to address key gaps in service capacity e.g the Denbigh Health and Social Care Programme. The Health Board have developed the Tuag Adref service in the West to provide for a reablement service and domiciliary care is now jointly commissioned by Local Authorities and the Health Board.	Tehmeena Ajmal, Chief Operating Officer	Ongoing			As part of the additional funding made available to the LAs to reduce the number of POCDs, the priority plans focus heavily on D2RA Pathway 1 – reduction in time taken to restart Package of Care (POC), increasing capacity by 15%. North Wales Dom Care Agreement now well established with 96% (100 providers) of providers having signed contracts. Trusted Assessor Model for returning people to their existing care home continues role out. Across the health board, five pilot projects in place—2 in Gwynedd, 1 in Ynys Môn, 1 in Flintshire, and 1 in Wrexham—outcomes are indicative of success in facilitating early, safe discharges and strengthening trust between the health board and participating care homes. Central pilots remain on hold pending assignment of a TA role, with coordination efforts underway with the Site Manager at YGC.
1424	Board Effectiveness Follow-up – Betsi Cadwaladr University Health Board	2024	Executive Team	A key priority for the new Chief Executive will be to build a stable, cohesive, and appropriately skilled Executive Team that can provide the organisation with the operational leadership it needs. This will include settling on the right mix of Executive Director portfolios, reducing reliance on interim arrangements for senior leadership roles, and building leadership capacity and capability for the Health Board's corporate governance	No management response within report	Carol Shillabeer, Chief Executive	N/A			No further update, this will be tested by Audit Wales as part of the Structured Assessment.
1453	Structured Assessment 2024	2024	Recommendation 2	2. In the context of ongoing work in relation to the Foundations of the Future programme and strengthening its operational governance the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role.	Currently there is no accountability or responsibility for the Senior Leadership Team in terms of operational governance, it is a mechanism by which the Members of the Executive Team can engage to support the delivery of the Health Board plans. As part of the Foundations for the Future Programme, clarity on roles and responsibilities for groups will be confirmed alongside the role of the Senior Leadership Team and the Operational Leadership Team. Key actions include: **• Review of the operational governance arrangements including the role of the Senior Leadership Team**	Pam Wenger, Director of Corporate Governance	31/07/2025	28/02/2026	1	The review of the role and function of the Senior Leadership Briefing is being undertaken and will be concluded by end of October 2025.
1456	Structured Assessment 2024	2024	Recommendation 5	5. The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board.	The Health Board is considering the most appropriate way to engage the wider Board in terms of visiting services. Individual Board Members visit sites on a regular basis. Key actions include: **• Agree how the Board can engage with services, which will include plans in terms of service reviews;** **• Establish a reporting mechanism to the Board in terms of**	Pam Wenger, Director of Corporate Governance	30/06/2025			The approach has been drafted and shared with the Chair. Further work is required to put in place the arrangements, the draft approach has been shared with Board Members.
1463	Review of Cost Savings Arrangements	2024	Recommendation 1.2	The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through: R1.2: Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan Health Board savings target.	R1.2 The articulation of demand and capacity by speciality and comparison to national metrics will enable allocative efficiency models to be endorsed. This will depend largely upon formation of the above speciality plans and Corporate benchmarking that will occur prior to and during 2025/26.	Russell Caldicott, Executive Director of Finance	31/10/2025			Work has commenced on the allocative efficiency model for 2026/27, with a number of opportunities having been initially identified which are being explored further.
1467	Review of Cost Savings Arrangements	2024	Recommendation 2.3	The Health Board should strengthen its approach to the identification and delivery of savings by: R2.3: Maintaining a focus on the identification of saving schemes that deliver recurrent savings.	R2.3 The Annual Plan (endorsed by the Board) sets out the expectation to deliver the annual savings requirement on a recurrent basis. The 2023/24 Full Year Effect (FYE) outturn was £26.3m which was in excess of the required target £25.2m. The 2024/25 current recurrent FYE forecast against the £48m Savings Target stands at £39.2m (at Month 6).	Russell Caldicott, Executive Director of Finance	31/03/2025			As at month 5 reporting the full year effect of recurrent savings for 25/26 is £27.8m against the target set for IHCs to find of £40m. The 25/26 financial plan recognised the full £40m may not be deliverable on a recurring basis and allowed for potential non delivery of £10m against this target.

1470	Review of Cost Savings Arrangements	2024	Recommendation 3.1	When updating its savings guidance, the Health Board should ensure: R3.1: That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas.	R3.1 The Health Board launched Small Change Big Difference in 2023, which sought ideas from all staff. We will continue to progress and follow up on these initiatives to secure enhanced savings delivery.	Russell Caldicott, Executive Director of Finance	Ongoing 2025			The proposal about how to refresh the 'Small Change big difference' is scheduled for the October programme board.
1514	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	**Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)** 2. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs. (OWNER: CHC Commisioning Manager)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	01/06/2025	1	This work is progressing via the North Wales Collaborative and Regional Leadership Group.
1520	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	**Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)** 8. Actively seek ways to increase local authority access for systems held within BCUHB. (OWNER: Acting Assistant Director of Care Homes Support)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	31/04/2025	1	There is limited progress on a system for the LAs to access information on POCDs and D2RA Dashboards. Information is shared following Census day to all LAs and the opportunity for bespoke reports have been made available. Progress has been made in allowing Social Care staff working on the acute sites to have access to Right Patient, Right Place dashboards that show the D2RA pathways for patients and EDD. In the West the dashboard now includes Community Resource Team capacity and demand - this will be rolled out across the region.
1682	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Identifying data used to inform plans for urgent and emergency care	R1. To ensure that priorities reflect and align to up to date information such as service demand, service capacity and future demographic pressures, the Health Board should clearly indicate the data used to inform its plans for urgent and emergency care (Exhibit 2).	The 6 Goals Delivery Plan includes specific benefits and measures to monitor the progress against the priorities for the 4 UEC workstreams. A number of Power BI dashboards have also been established to support access to a range of live data across UEC, enabling oversight of activity across acute and community sites, any emerging pressures and monitoring delayed patients. UEC data will be reviewed within the IHC local governance structures for UEC, the UEC programme board and UEC internal focus group to continue to inform plans and priorities.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025
1683	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Risk management within plans	R2. To strengthen risk management, the Health Board should ensure that all risks set out in urgent and emergency care plans have risk owners, clear scores and targets as well as robust mitigating actions (Exhibit 2).	R2.1 The 4 UEC workstreams have RAID logs that are either developed or in development that include risks, actions, issues, decisions which are reviewed during each workstream meeting that are held regularly with standard agendas.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			New report added to tracker in October 2025
1684	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Risk management within plans	R2. To strengthen risk management, the Health Board should ensure that all risks set out in urgent and emergency care plans have risk owners, clear scores and targets as well as robust mitigating actions (Exhibit 2).	R2.2 A Health Board corporate risk CRR25-01 (Timely Patient Access to Safe & Effective Care) includes mitigating actions and controls across UEC as well as wider services.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026			New report added to tracker in October 2025
1685	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Alignment between IHC and corporate urgent and emergency care plans	R3. To ensure that the actions taking place within Integrated Health Communities align with the corporate vision of the Health Board, it should develop IHC delivery plans to implement the vision of the corporate Six Goals Plan which sets out a consistent approach to track performance of the overarching urgent and emergency care plan delivery across each IHC area (Exhibit 2).	R3. The 6 Goals transformation programme and delivery plan is a single regional plan which will be delivered within each of the IHCs (as the current service configuration) to ensure consistency of approach. This will include a detailed deployment / implementation plan across different sites and services rather than having three additional locality based plans. The rationale for this is to ensure development of a single model for the Health Board to drive out unwarranted variation.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			New report added to tracker in October 2025
1686	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Resourcing urgent and emergency care plans	R4. To provide clarity on how initiatives will be funded beyond the annual plan cycle, the Health Board should ensure its plans for urgent and emergency care clearly identify funding needs for current and future years, as well as identifying the sources of funding (Exhibit 2).	Additional 6 Goals funding has been made available nationally, which is contingent on a detailed financial plan and which has been submitted to the national NHS P&I team. As regional service models are developed, resource implications will be integrated into annual financial plans and within the IMTP.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			New report added to tracker in October 2025
1687	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Resourcing urgent and emergency care plans	R5 To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements (Exhibit 2).	R5. Workforce requirements will be assessed as part of the development of a regional model for urgent and emergency care and to support requirements of R4.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			New report added to tracker in October 2025

1688	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	R6. To help guide patients to the most appropriate service for their needs, the Health Board's website should include advice on key urgent conditions, such as breathing difficulty, chest pain or rashes (Paragraph 26)	R6. The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the 'Help Us Help You' campaign.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025
1689	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	R7. To help address demand for urgent care, the Health Board should ensure GP and dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance (Paragraph 28).	R7. The BCU website includes information about local primary care services; including access to dental and GP services that includes a page with a directory of information of all GP practices in NW as a core part of seasonal campaigns to sign post to information.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025
1690	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	R8. To support staff and public understanding of the breadth of urgent and emergency services within the Health Board, and how to access them, the Health Board should develop a communications plan for urgent and emergency care services (Paragraph 33).	A GMS sustainability action plans includes a focus on public comms, including identification of relevant items for communication and work is ongoing with corporate comms team to agree a communications plan including how community pharmacies can support. The website also includes a link to NHS 111 providing information and a point of signposting which includes all directories for primary care services and is the single point of contact in terms of supporting the public with decisions on these services.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025
1691	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	R9. To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task (Paragraph 37).	R9.1 The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the 'Help Us Help You' campaign	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			New report added to tracker in October 2025
1692	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	R9. To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task (Paragraph 37).	R9.2 A clinical lead has been identified to roll out our Single Point of Access model, which includes an accurate and up to date directory of services to support referral into appropriate services. This will initially be supported by the 6 Goals project team. The lead role will be designated following the reconfiguration of services.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			New report added to tracker in October 2025
1693	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	R10. To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee (Paragraph 52)	R10. As part of the 6 Goals programme a review will be undertaken to evaluate the SDEC models currently in place on each of the 3 acute sites in North Wales, including an analysis of utilisation by WAST and ED to support streaming, and outcomes for patients. The NHS P&I team are conducting an assurance	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			New report added to tracker in October 2025
1694	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	R11. To ensure Urgent Primary Care Centres are being maximised, the Health Board should: R11.1 Work with key partners, including GPs and Emergency Department leads, to review the UPCC referral criteria. R11.2 Ensure the UPCC referral criteria is well-communicated and accessible to relevant staff, once agreed (Paragraph 56)	R11. BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026			New report added to tracker in October 2025
1695	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of Minor Injuries Units	R12 To understand how well it is utilising Minor Injuries Units and to identify further opportunities to maximise this service, the Health Board should include metrics on attendance and conveyance rates to its minor injuries units and medical assessment units in reports to the Finance and Performance Committee (paragraph 62).	R12. A power BI dashboard is established that includes a suite of reports for MIU performance data including number of attendances, time to triage & clinician / number of breaches. UEC data will be reviewed and scrutinised within the UEC programme board and other relevant forums as agreed with the COO to inform the development of plans and priorities.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025

1696	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving staff and patient feedback	R13. To ensure future plans for urgent and emergency care are informed by patient experience, the Health Board should clearly demonstrate within the narrative how it has considered patient feedback (Exhibit 9).	R13. The UEC programme board receives a patient story as a standing item on the agenda. A review of complaints and compliments is routinely undertaken by IHCs respectively. As part of the focused work within UEC workstream 4, Discharge Improvement Groups have been established in each of the 3 IHCs to review discharges that are considered to provide learning, identify themes and trends	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025
1697	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving staff and patient feedback	R14. To improve the understanding of how services are working, and identify potential weaknesses or learning from recent changes, the Health Board should introduce regular mechanisms for staff feedback on urgent and emergency care services. This should include feedback from key partners including primary care and WAST staff (Exhibit 9).	R14. Targeted work has been done with care homes and actions to improve the patient experience which is included within care home awareness seminars. Follow up audits have been undertaken in the 3 ED departments specifically for attendances from care homes into the EDs. This has included engagement with staff from care homes & EDs. Learning from this has been incorporated into the ongoing care home awareness webinars that are being rolled out across NW within a rolling programme of awareness raising and training	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025
1698	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Reporting of expenditure of additional funding for UEC services	R15. To increase transparency and strengthen assurance that monies allocated to the Health Board for urgent and emergency care is being spent wisely, the Health Board should include information on its use of additional funding within regular finance reports to the Performance, Finance and Information Governance Committee. This should include the use of Six Goals, Further Faster and Regional Integration Fund monies (Exhibit 10).	R15. The UEC (6 goals) programme board approved the 6 Goals financial plan that is aligned to the 6 Goals programme plan prior to submission to WG earlier this year. The UEC / 6 Goals programme board will receive regular finance reports on UEC / 6 Goals and wider Further Faster / RIF funding as a standing item which includes review with LA partners.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			New report added to tracker in October 2025

SUMMARY OF AUDIT WALES RECOMMENDATIONS APPROVED FOR CLOSURE BY EXECUTIVE TEAM MEMBER AND EXECUTIVE COMMITTEE

			Summary of recommendation with rationale for closure
EXECUTIVE DIRECTOR OF FINANCE			
1	1462	Review of Cost Savings Arrangements	The 25/26 budget was set based upon information relating to the underlying position, as provided by the finance leads for individual IHCs. The information contained detail around cost pressures, and these were considered on the basis of avoidable and unavoidable, with some difficult decisions needing to be made regarding what could and couldn't be funded to enable the setting of a balanced budget. Some of the pressures that haven't been funded are identified as a risk, and these are being managed. In addition some developments are still under consideration, with funding remaining in reserves for the short term. The prioritisation of these funds is now being carried out by the planning team and is scheduled to conclude shortly.
2	1471		The guidance has been updated to include reference to the V & S framework.

Name	Review Date	Responsible Director	Q2 2025/26 Updates
BCUHB - Claims Governance Policy Clinical Negligence and Personal Injury - V8.pdf	01/07/2021	Director of Corporate Governance	*Currently under review*
CRF01 - North Wales Clinical Research Facility (NWCRF) - Operational Framework Policy.pdf	15/08/2025	Executive Medical Director	*No progress update received*
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	01/09/2019	Chief Operating Officer	*No progress update received*
ES01 - BCUHB Asbestos Policy & Management Plan.pdf	31/05/2025	Director of Environment and Estates	*No progress update received*
ES02 - Policy for the Management of Safe Water Systems.pdf	10/05/2025	Director of Environment and Estates	*No progress update received*
ES03 - Waste Management Policy - V5.pdf	01/09/2023	Director of Environment and Estates	*No progress update received*
ES04 - Policy for the Managment of Fire Safety - V0.4.pdf	01/04/2022	Director of Environment and Estates	*Draft document due to be submitted to the Fire Safety Management meeting on 18th December 2025, and Occupational Health and Safety meeting on 16th February 2026*
ES05 - Policy for the Management of Ventilation Systems - V1.0.pdf	08/03/2025	Director of Environment and Estates	*No progress update received*
F02 - Lease Car & Pool Vehicle Policy and Procedure - V.03.pdf	15/08/2024	Executive Director of Finance	*No progress update received*
HS23 - CCTV and Body Worn Video (BWV) Policy - V1.0.pdf	15/03/2025	Executive Director of Workforce and Organisational Development	People Services have asked the Director of Estates and Environment for agreement this WCD can be aligned to his office
ISU03 - Volunteering Policy - V0.1.pdf	12/01/2017	Executive Director of Workforce and Organisational Development	*No progress update received*
MD01 - Policy on Consent to Examination or Treatment (Based on the All Wales Model Policy) .pdf	01/09/2025	Executive Medical Director	Review has already started to be considered (since March 2025) as the BCUHB Consent Policy is a standing agenda item on the BCUHB Decision Making and Consent Strategic Working Group (Consent Group) agenda. Although the BCUHB Consent Policy has a formal 3 yearly review date, it has had minor updates within the 3 yearly formal cycle of review to e.g. ensure links are up to date. The Chair of the Consent Group has decided to align the timescale of the next substantive review of the BCUHB Consent Policy with the national review of the All Wales Model Policy which is currently taking place.
MD10 - Medical & Dental Staff Study Leave Policy - V0.1.pdf	20/10/2017	Executive Medical Director	*No progress update received*

MD11 - Medical & Dental Staff Professional Leave Policy - V0.1.pdf	20/10/2017	Executive Medical Director	*No progress update received*
MD13 - Annual Leave & Special Leave Policy for Medical & Dental Staff - V0.1.pdf	20/10/2017	Executive Medical Director	*No progress update received*
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	01/09/2021	Executive Medical Director	*No progress update received*
MD22 - Clinical Audit Policy and Procedure .pdf	10/09/2025	Executive Medical Director	*No progress update received*
MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	01/03/2024	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MHLD 0026 - Policy for Admission, Receipt and Scrutiny of Statutory Documentation.pdf	29/04/2025	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	01/07/2020	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf	01/06/2019	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf	01/10/2023	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf	01/04/2021	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	15/01/2024	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf	01/05/2022	Executive Director of Allied Health Professions and Health Science	*No progress update received*
MM01 - BCUHB Medicines Policy .pdf	31/12/2023	Executive Medical Director	*No progress update received*
MM02 - Injectable Medicines Policy.pdf	08/07/2022	Executive Medical Director	*No progress update received*
MM03 - Procedure for Supplementary (SP) and Independent (IP) Prescribers (1).pdf	01/04/2025	Executive Medical Director	*No progress update received*

MM05 - Intrathecal Chemotherapy Policy - V3.pdf	01/03/2021	Executive Medical Director	Classification of the document as a policy has been confirmed. Policy delayed due to possibility of the operational need to centralise the Intrathecal service onto one site. This will impact on policy content. An SBAR is being prepared for consideration by cancer services and for a decision on location of centralised service.
MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf	01/02/2022	Executive Medical Director	On MPPP Agenda for August
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	01/05/2021	Executive Medical Director	*No progress update received*
NU28 - Nurse Staffing Levels Policy.pdf	01/01/2025	Executive Director of Nursing	*Policy and associated documents under review and being consulted on via Senior Nursing Team and Workforce. Tabled for Workforce Policy Group 18th July 2025. It will progress to PSG and EQDG in following weeks.*
PTR02 - Claims Management Policy.pdf	05/06/2017	Director of Corporate Governance	*Currently under review.*
RD01 - Research Governance Policy.pdf	17/08/2025	Executive Medical Director	*No progress update received*
RD02 - Policy for Research Involving Ionising & Non Ionising Radiation.pdf	25/05/2025	Executive Medical Director	*No progress update received*
RD03 - Policy for Intellectual Property - V2.pdf	01/08/2022	Executive Medical Director	*No progress update received*
RD04 - NHS R&D Finance Policy - V1.0.pdf	20/07/2019	Executive Medical Director	*No progress update received*
RES03 - Cardiopulmonary Resuscitation (CPR) Policy.pdf	31/08/2025	Executive Medical Director	*No progress update received*
TU1 - Policy & Procedure for Top up Payments - V0.2.pdf	01/05/2017	Executive Medical Director	*No progress update received*
WP29 - BCU Relocation Expenses Policy V0.3.pdf	05/12/2019	Executive Director of Workforce and Organisational Development	We are pausing any work on the local policy as a new NHS Wales Expenses draft policy has been circulated recently, we are aware of a planned national review in October
WP52 - Study Leave Policy - (Applies to all staff apart from Medical & Dental) - V0.2.pdf	01/01/2018	Executive Director of Workforce and Organisational Development	Policy will be presented to Workforce Policy Group in October (24/10/2025)
WP69 - Employer Pension Contributions – Alternative Payment Policy.pdf	01/03/2025	Executive Director of Workforce and Organisational Development	This has now been scheduled for Policy Group in February 2026.

MINISTERIAL DIRECTIONS

MD ID	Publication date	Ministerial Direction title	Link to Ministerial Direction	Description	Executive Lead	Action required Yes/No/ Unknown at present	Update on action	All action completed Yes/No/ Partial
WG25-17	22/04/2025	Directions to LHBs as to the Statement of Financial entitlements (Amendment) (No. 2) Directions 2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2025 | GOV.WALES	It relates to LHBs and payments to be made by them to GMS contractor under a GMS contract	Russell Caldicott, Executive Finance Director	No	**25/02/2025** Forwarded to Russell Caldicott, cc Natalie, Tehmeena Ajmal & Pam Wenger 05/03/2025 - email from Natalie, closed no actions .	Yes
WG25-27	19/05/2025	The Primary Medical Services (Intra-Periarticular Injections) (Directed Supplementary Services (Wales) Directions 2025	The Primary Medical Services (Intra-Periarticular Injections) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES	Intra/periarticular injections occurring in the community, a popular service with both patients and GPs. However, there is evidence of unwarranted variation in commissioning and/or provision of intra/periarticular injections, or schemes have promoted lower value interventions over higher value ones.	Clara Day, Executive Medical Director (Sreeman Andole, Interim Executive Medical Director when published)	Unknown	**19/06/2025** forwarded to Sree Andole, cc Marie Davies & Pam Wenger	No
WG25-28	19/05/2025	The Primary Medical Services (Minor Surgery)(Directed Supplementary Services (Wales) Directions 2025	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES	Minor surgery that takes place outside hospitals has been popular with both patients and GPs, however, there is evidence of unwarranted variation in commissioning and/or provision of minor surgery, or schemes have promoted lower value interventions over higher value ones. This Minor Surgery Directed Supplementary Service (DSS) is designed to promote a flexible and rational approach to managing dermatological lesions by promoting higher value procedures being delivered as close to home as possible.	Clara Day, Executive Medical Director (Sreeman Andole, Interim Executive Medical Director when published)	Unknown	**19/06/2025** forwarded to Sree Andole, cc Marie Davies & Pam Wenger	No
WG25-30	30/05/2025	The Primary Care (Contracted Services: Immunisations) (Influenza) directions 2025	The Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025 | GOV.WALES	Each Local Health Board must establish, operate and, as appropriate, revise a Scheme in accordance with these Directions and the relevant specification	Jane Moore, Executive Director of Public Health	Unknown	**19/06/2025** Forwarded to Jane Moore, Pam Wenger and Rhian Baker **19/06/2025** Lois Lloyd confirmed shared with team, requesting updates	Partial
WG25-33	09/06/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025 | GOV.WALES	Regarding amendments to the financial entitlements for Chronic Kidney Disease (CKD), which affects 7.62% of the Welsh population aged over 16 years (n= 196,815), and prevalence has increased by 33% over the last 12 years.1 Of the 4 nations, Wales has the second highest prevalence of End stage kidney disease (ESKD) requiring of renal replacement therapy (RRT) per million population2 . Within Wales, RRT services are commissioned via the Wales Kidney Network (WKN), with an annual budget of £80 million, although the total economic burden of CKD in Wales is estimated to be in excess of £320 million (extrapolated from UK spend of £7 billion per year)3 . ESKD is associated with markedly increased mortality and poor quality of life, additionally dialysis is an expensive therapy (approx. £30K per annum). In view of this, it is imperative that patients with CKD are identified early and that appropriate steps are taken to mitigate against disease progression.	Russell Caldicott, Executive Financial Director	No	**19/06/2025** Forwarded to Russell Caldicott, Natalie Morrice-Evans and Pam Wenger. **03/10/2025** - update requested 06/10/25 - Natalie confirmed action closed	Yes
WG25-38	23/07/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025 | GOV.WALES	Directions with effect and compliance with requirements of section 45(3)e of the NHS Service Act 2006, in relation to the Statement of Financial Entitlements and payments made by Local Health Boards to a GMS contractor under GMS contract	Tehmeena Ajmal, COO	No	18.09.2025 - emailed Natalie Morrice-Evans, Pam Wenger and Philippa Peake-Jones 23.09.25 - forwarded to Tehmeena Ajmal and Lynne Joannou as advised by Pam Wenger 23.09.25 - Lynne Joannou confirmed closed	Yes
WG25-39	08/08/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2025	https://www.gov.wales/directions-local-health-boards-statement-financial-entitlements-amendment-no-5-directions-2025	In relation to the Statement of Financial Entitlements and payments made by Local Health Boards to a GMS contractor under GMS contract regarding the shingles immunisation programme.	Tehmeena Ajmal, COO	Unknown	18.09.2025 - emailed Natalie Morrice-Evans, Pam Wenger and Philippa Peake-Jones 23.09.25 - forwarded to Tehmeena Ajmal, Linda Thomas and Claire Brennan as advised by Pam Wenger	No

WG25-40	13/08/2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) (Amendment) Directions 2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults (Directed Supplementary Service) (Wales) (Amendment) Directions 2025 | GOV.WALES	Amendment of the Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults	Tehmeena Ajmal, COO	No	22.09.25 - emailed Marie Davies querying person to send to (exec med director or lead of primary care) 23.09.25 - Lynne Joannua confirmed action closed	Yes
WG25-44	04/09/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025	These directions raise payments to dental foundation trainees and trainers for 2025 to 2026	Russell Caldicott, Executive Director of Finance	Unknown	22.09.25 - emailed Natalie Morrice-Evans cc'd Pam Wenger and Philippa Peake-Jones 22.09.25 - Natalie forwarded to Paul Carter for update 23.09.25 - forwarded to Tehmeena Ajmal, Linda Thomas and Claire Brennan	No
WG25-45	04/09/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No 4) Directions 2025 | GOV.WALES	These directions raise payments to dental foundation trainees and trainers for 2025 to 2026	Russell Caldicott, Executive Director of Finance	Unknown	22.09.25 - emailed Natalie Morrice-Evans cc'd Pam Wenger and Philippa Peake-Jones 22.09.25 - Natalie forwarded to Paul Carter for update 23.09.25 - forwarded to Tehmeena Ajmal, Linda Thomas and Claire Brennan	No
WG25-56	30/09/2025	The directed supplementary services directions and specification for people living with severe frailty in their own homes 2025	The directed supplementary services directions and specification for people living with severe frailty in their own homes 2025 | GOV.WALES	Direction to those in primary care	Tehmeena Ajmal, COO	Unknown	29.10.25 - emailed Tehmeena Ajmal, Claire Brennan, Pam Wenger & Philippa Peake-Jones	No

WELSH HEALTH CIRCULARS

WHC ID	Publication date	Welsh Health Circular Title	Link to WHC - either WG website or internal folder	Description	Executive Lead	Details of Action Taken	All action completed Yes/No/ Partial
WHC/2024/025	02/04/2025	NHS Wales national clinical audit and outcome review plan 2024 to 2025	NHS Wales national clinical audit and outcome review plan 2024 to 2025 (WHC/025/24)	How we will measure the quality and safety of healthcare services as part of an annual rolling programme	Nick Lyons, Executive Medical Director	**17/06/2024** James Risley confirmed that this has gone through SCEG (Strategic Clinical Effectiveness Group) and therefore no further action required. **NO FURTHER ACTION REQUIRED**	Yes
WHC/2025/004	23/04/2025	National Clinical Audit Plan 2025-26	NHS Wales national clinical audit and outcome review plan 2025 to 2026 (WHC/2025/004) | GOV.WALES	NHS Wales national clinical audit and outcome review plan 2025 to 2026	Clara Day, Executive Medical Director (previously Sreeman Andole, Interim Executive Medical Director)	03/10/2025 - update requested	No
WHC/2025/006	13/05/2025	Mental Health Outcomes Measures	Welsh Health Circulars\Letters\2025\WHC 2025 006\Recording of Mental Health Outcomes Measures - English.pdf	Guidance in relation to adopting the use of Patient Reported Outcome Measures (PROMs) in Mental Health Services	Teresa Owen, Executive Director Allied Health Professionals and Health Science	03.10.25 - update requested	No
WHC/2025/008	27/06/2025	Licensing scheme for special procedures in Wales	Licensing scheme for special procedures in Wales (WHC/2025/008) | GOV.WALES	Part 4 of the Public Health (Wales) Act 2017: Introduction of a National Mandatory Licensing Scheme for Special Procedures in Wales	Jane Moore, Executive Director of Public Health	03.10.25 - update requested 14.10.25 - update from Sam Lauder, confirmed communicated with all IHC directors and info posted on betsinet. Action closed	Yes
WHC/2025/010	11/04/2025	Letter to Primary Care re Antiviral Prescribing COVID-19	Welsh Health Circulars\Letters\2025\WHC 2025 010\WHC 2025 010 - Draft Letter to Primary Care to Antiviral Prescribing COVID-19 - English.pdf	Arrangements for the prescriing of antiviral and neutralising monoclonal antibody treatments for COVID-19.	Tehmeena Ajmal, Chief Operating Officer	03.10.25 - update requested 06.10.25 - Lois Lloyd advised action closed	Yes
WHC/2025/011	11/04/2025	Introduction of the NHS Wales Digital Health Identity Standard for Primary Care (NHS Login)	Welsh Health Circulars\Letters\2025\WHC 2025 011\20250408 WHC 2025-11 - Introduction of WIVS- English.pdf	The NHS Wales Digital Health Identity Standard for Primary Care (NHS Login) sets out a consistent approach to identity management in GP practice. It describes why a person should prove their identity to access digital health services. The Standard also sets out how the identity verification process, identity autherntication and authorisation should be performed in a GP practice setting.	Tehmeena Ajmal, Chief Operating Officer	03.10.25 update requested	No
WHC/2025/012	24/06/2025	Interim changes to NHS model standing financial instructions	Interim changes to NHS model standing financial instructions (WHC/2025/012) | GOV.WALES	A letter about updates to NHS Wales financial procedures when buying goods and services	Russell Caldicott, Interim Executive Director of Finance	28.10.25 - email sent to RC, PW, PPJ and NME 29.10.25 - advised by PW via email, implemented at sept 25 board	Yes
WHC/2025/013	24/04/2025	NHS Wales financial monitoring return guidance: 2025 to 2026	NHS Wales financial monitoring return guidance: 2025 to 2026 (WHC/2025/013) | GOV.WALES	Guidance for health boards, special health authorities and trusts on monthly financial returns	Russell Caldicott, Interim Executive Director of Finance	28.10.25 - email sent to RC, PW, PPJ and NME	No
WHC/2025/015	22/04/2025	People's experience framework	People's experience framework (WHC/2024/015) | GOV.WALES	This circular discusses the framework which notes how people's experience of NHS settings gets due regard	Angela Wood, Executive Director of Nursing	28.10.25 - email sent to AW, PW, PPJ and NS 28.10.25 - AW advised close	Yes

WHC/2025/016	06/05/2025	Update on NHS Wales vaccination programmes against respiratory syncytial virus (RSV)	Welsh Health Circulars\Letters\2025\WHC 2025 016	The RSV programmes was introduced in Wales to mitigate the significant impact the virus has on citizens and primary and secondary care services. 90% of children will be infected with RSV by aged 2 yrs. The risk of severe illness is highest in those under 6 months.The total burden of mortality, morbidity and healthcare usae related to RSV is at least equivalent to that of influenza. Current uptake rates are significantly lower that influenza and there is the need to improve uptake of RSV vaccine.	Jane Moore, Executive Director of Public Health	03.10.25 - update requested 07.11.25 - update requested	No
WHC/2025/017	12/05/2025	Tranexamic acid use Infected Blood Inquiry	Welsh Health Circulars\Letters\2025\WHC 2025 017\Tranexamic acid use Infected Blood Inquiry - English.pdf	Following the publication of the Infected Blood Inquiry and its recommendations (20.05.25), the oversight group has amended recommendation 7 Patient Safety: Blood Transfusion and specifically recommendation 7a Tranexamic Acid use.	Clara Day, Executive Medical Director (previously Sreeman Andole, Interim Executive Medical Director)	**07/05/2025** Sree Andole provided his action plan to support the implementation of the patient safety measures within the organization. He confirmed that he has already taken the following actions: 1. He has reviewed and is actively implementing the guidance from the Joint Royal Colleges Tranexamic Acid in Surgery Implementation Group and are ensuring compliance with NICE quality standard QS138. 2. His surgical teams have updated all surgical checklists to include Tranexamic Acid administration for eligible procedures. 3. He has established a working group to standardize and benchmark our transfusion performance against other hospitals to improve our patient blood management protocols. Furthermore, regarding the additional recommendations for broader patient blood management: 1. He is fully supporting and implementing the NHS Wales Preoperative Anaemia Pathway across all relevant departments. 2 He has updated the surgical checklists to include Intraoperative Cell Salvage (ICS) as a standard consideration. The IHC Medical Directors and Surgical Leads have been instrumental in driving these changes, and we have scheduled a comprehensive audit for later this month to evaluate implementation progress and identify any areas requiring additional support. Sree will ensure that detailed documentation of the implementation progress is submitted to qualityandnursing@gov.wales before the June 4th, 2025 deadline.	Partial
WHC/2025/018	09/05/2025	Tirzepatide (Monjouro®) for the management of obesity and overweight	Welsh Health Circulars\Letters\2025\WHC 2025 018\Tirzepatide (Monjouro®) for the management of obesity and overweight - Eng.pdf	on 3.7.24 an addendum to the All Wales Weight Management Pathway (AWWMP) was published regarding the use of weight loss medications for thos patients in Wales meeting the appropriate clinical criteria as described in (WHC/2024/030) Published Weight Medication Management Pathway. The addendum makes it clear that the prescribing of Glucagon-Like Peptide-1 Receptor Agonists (GLP 1RAs) including Semaglitude should take place within the confines of the appropriate level of the AWWMP, most likely Level 3, with some appropriate use in levels 2 & 4 in line with NICE guidelines.	Clara Day, Executive Medical Director (previously Sreeman Andole, Interim Executive Medical Director)	**12/05/2025** Lois Lloyd confirmed that this WHC will be on Drug & Therapeutics Agenda for information in June. Will then be assessed at the BCUHB NICE/AWMSG Impact Assessment Group Meeting once we have received an application from the Weight Management service (application is underway). Jane Moore copied in for awareness due to cross cutting portfolios on weight management with public health.	Partial
WHC/2025/019	12/05/2025	Changes to the routine childhood vaccination schedule and to the selective hepatitis B vaccination programme from 01 July 2025	Welsh Health Circulars\Letters\2025\WHC 2025 019	Information regarding significant changes to the routine childhood vaccination schedule and to the selective hepatitis B (HepB) programme, which will start from 1 July 2025, with further changes commencing from 1 January 2026, required to optimise the protection of children in Wales.	Jane Moore, Executive Director of Public Health	03.10.25 - update requested 28.10.25 - update received from Kailey Ben-Sassi. Action closed.	Yes
WHC/2025/020	12/08/2025	The national influenza immunisation programme 2025 to 2026	The national influenza immunisation programme 2025 to 2026 (WHC/2025/020) | GOV.WALES	Letter to health professionals about the vaccinations with several changes and detailed guidance	Jane Moore, Executive Director of Public Health	28.10.25 - email sent to JM, PW, PPJ and RB 29.10.25 - update from PW. Action in hand	Yes
WHC/2025/021	11/06/2025	Introduction of routine vaccinations for mpox and gonorrhoea	Introduction of routine vaccinations for mpox and gonorrhoea (WHC/2025/021) | GOV.WALES	The Welsh Government has accepted advice from the Joint Committee on Vaccination and Immunisation (JCVI) to introduce a routine targeted vaccination programme for the prevention of gonorrhoea, alongside a routine vaccination programme against Mpox for those at highest risk.	Jane Moore, Executive Director of Public Health	28.10.25 - email sent to JM, PW, PPJ and RB 07.11.25 - RB forwarded email for reponse to Kailey Ben-Sassi and Sam Lauder	No

WHC/2025/022	26/06/2025	The National COVID-19 Vaccination Programme Autumn 2025	Welsh Health Circulars\Letters\2025\WHC 2025 022\25-06-25 WHC 2025 022 - National COVID-19 Vaccination Programme - English.pdf	Provides detailed guidance for the COVID-19 vaccination programme for the coming autumn 2025 (National COVID-19 Vaccination Programme Autumn 2025).	Jane Moore, Executive Director of Public Health	01/09/2025 Received confirmatory email from Hannah Aucutt-Bracegirdle. Consent for data sharing and submission to VPW on 15/8/2025	Yes
WHC/2025/023	16/06/2025	PPE stockpile volumes in Wales	PPE stockpile volumes in Wales (WHC/2025/023) | GOV.WALES	An update on the Welsh Government review of target volumes for PPE stockpiling in Wales	Jane Moore, Executive Director of Public Health	28-10-25 - email sent to AW, JM, RB, PPJ & NS. 07.11.25 - email from Sharon Scott. Close action	Yes
WHC/2025/025	14/07/2025	Overseas Visitors' Eligibility to Receive Free Primary Care	Overseas visitors' eligibility to receive free primary care (WHC/2025/025) | GOV.WALES	This circular clarifies the circumstances when overseas visitors are entitled to free primary care. In all other circumstances further advice must be sought from Local Health Board (LHB) Overseas Visitors Managers (OVMs) to determine free primary and secondary care. It replaces WHC 2021/026.			
WHC/2025/026	05/08/2025	The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings	The safe and responsible adoption of ambient voice technologies (AI scribes) in clinical settings (WHC/2025/026) | GOV.WALES	The WHC provides an interim position on the introduction and use of artificial intelligence and machine learning in the form of ambient voice technologies (AVTs) in clinical and practice settings.	13/8/25 Unsure - awaiting response from Pam	03.10.25 - query exec lead	
WHC/2025/027	17/07/2025	A letter to health boards to update on changes to the supply of Gluten Free foods in Wales	All-Wales gluten free subsidy card scheme (WHC/2025/027) | GOV.WALES	The Cabinet Secretary for Health and Social Care has agreed to the implementation of an all-Wales Gluten Free (GF) subsidy card scheme for patients with a diagnosis of coeliac disease or dermatitis herpetiformis in Wales.	Jane Moore, Executive Director of Public Health	**16.7.25** Rec'd email from Lois seeking clarification from Sue Brierley Hobson, Tteresa Owen and Neil Windsor - see email in file for full details. 03.10.25 - update requested 08/10/25 - update from Steve Grayston & Lois Lloyd - action ongoing, to remain open	Partial
WHC/2025/028	09/07/2025	Expansion of the shingles immunisation programme for severely immunosuppressed individuals aged 18-49	Expansion of shingles immunisation for severely immunosuppressed people aged 18 to 49 (WHC/2025/028) | GOV.WALES	This letter is aimed at health professionals who will deliver the shingles vaccination programmes in Wales. I encourage you to share this guidance with all those involved in delivering the programme in your area.	Jane Moore, Executive Director of Public Health	03.10.25 - update requested 07.11.25 - update requested	No
WHC/2025/029	14/07/2025	Introduction of Nirsevimab passive immunisation against Respiratory Syncytial Virus (RSV) in at risk infants for upcoming 2025/26 RSV Season (Eng & Welsh) PDFs	Introduction of a new RSV passive immunisation from autumn 2025 (WHC/2025/029) [HTML] | GOV.WALES	Globally, RSV infects up to 90% of children within the first two years of life and frequently reinfects older children and adults. As part of the considerations around the establishment of an RSV vaccination programme, the JCVI has provided further advice on the selective RSV neonate programme. The Committee now supports a change to the product used, recommending Nirsevimab instead of Palivizumab, due to its higher efficacy, subject to it being procured at a cost-effective price. The JCVI also advised an expansion to the eligibility for the neonate programme, offering Nirsevimab to all infants born at <32 weeks.	Jane Moore, Executive Director of Public Health	03.10.25 - update requested 21.10.25 - Rhian Baker emailed Lois Lloyd and Kailey Ben-Sassi for update 22.10.25 - Kailey to send update by end of this week 07.11.25 - update requested	No
WHC/2025/031	26/09/2025	3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting	\\BCUeStorage\Office of the Board Secretary\Statutory Compliance\03 LEGISLATION\Welsh Health Circulars\Letters\2025\WHC 2025 031	3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting	Tehmeena Ajmal, Chief Operating Officer	30.09.25 - sent to Pam Wenger, Philippa Peake-Jones, Tehmeena Ajmal and Claire Brennan	

WHC/2025/032	24/06/2025	Amendments to Model Standing Orders and Model Standing Financial Instructions	Amendments to Model Standing Orders and Model Standing Financial Instructions – NHS Wales (WHC/2023/032) | GOV.WALES	Review of a) odel Stnading Orders, Reservations and Delegation of Powers and Standing Financial Instructions - Local Health Boards, NHS Trusts, Digital Health & Care Wales, Health Education and Improvement Wales, Welsh Health Specialised Services Committee (WHSSC) and, B) Review of Model Standing Orders, Reservations and Delegation of Powers - Emergency Ambulance Services Committee (EASC)	Pam Wenger, Director of Corporate Governance/Russell Caldicott, Executive Director of Finance	23.09.25 - Pam advised action complete as went to Audit Committee in August 2025	Yes
WHC/2025/034	25/09/2025	Welsh Health Circular in respect of MODS Phase 1 Planned Care Referrals DSCN	\\BCUeStorage\Office of the Board Secretary\Statutory Compliance\03 LEGISLATION\Welsh Health Circulars\Letters\2025\WHC 2025 034	Implementation of planned care referrals	Tehmeena Ajmal, Chief Operating Officer	25.09.25 - forwarded to Pam Wenger and Philippa Peake-Jones 26.09.25 - forwarded onto Tehmeena Ajmal and Claire Brennan	No
WHC/2025/037	25/09/2025	Infected Blood Inquiry: Implementation of Recommendation 7e: Implementing SHOT reports	\\BCUeStorage\Office of the Board Secretary\Statutory Compliance\03 LEGISLATION\Welsh Health Circulars\Letters\2025\WHC 2025 037	Implementation recommendations: Infected Blood Inquiry	Clara Day, Executive Medical Director	25.09.25 - forwarded to Pam Wenger and Philippa Peake-Jones 26.09.25 - forwarded to Marie Davies FAO Clara	No
WHC/2025/038	22/09/2025	ll-Wales NHS Accessible Communication and Information Standards	Welsh Health Circular ACIS_EN.pdf	Reviewed and renewed standards: 'All-Wales NHS Accessible Communication and Information Standards'	Georgina Roberts, Associate Director of People's Services	22.09.25 - Fiona Lewis emailed circulation 22.09.25 = Gill Querci advised T&F Group established April 2025 lead by Ceri Harris, Head oF Equality & Human Rights. Email further shared with Ceri Harris. Query for briefing to be submitted to future Exec Committee meeting noting impact of standards	Yes

Teitl adroddiad: ***Report title:***	Revised Policy Management Process
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025
Argymhellion: ***Recommendations:***	The Committee is asked to: • **NOTE** the proposed policy management process and updated draft Corporate Policy Management Policy • **APPROVE** the proposed policy management process and updated draft Corporate Policy Management Policy • **NOTE** that the final draft Corporate Policy Management Policy will be considered at the Audit Committee in December 2025.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Glesni Driver, Head of Statutory Compliance and Inquiries

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Not applicable, other than those relating to individual policies, procedures and other written control documents
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has up to date and accurate policies, procedures and other written control documents in order to comply with relevant legislation and minimise any associated risk
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	There are risks relating to policies, procedures and other written control documents that have passed their 1-year or 3-year mandatory review period following initial approval. It is essential that the Health Board has up-to-date and accurate policies and written control documents in order to comply with relevant legislation and minimise any associated risk
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith*	Not applicable, other than those relating to individual policies, procedures and other written control documents

Financial implications as a result of implementing the recommendations	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual policies, procedures and other written control documents
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Updates from the initial consultation around the revised policy management process have been incorporated. Once reviewed by the Executive Team and Audit Committee, the Policy Management Policy and Policy Management Procedure will be submitted onto BetsiNet for Health Board-wide consultation, with updates made as necessary, with the current approval routes followed for both the Policy and Procedure prior to publication.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable, other than those relating to individual policies, procedures and other written control documents.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Once reviewed by the Executive Committee and Audit Committee, the Corporate Policy Management Policy and Corporate Policy Management Procedure will be submitted onto BetsiNet for Health Board-wide consultation, with updates made as necessary at the end of that consultation period, and the current approval routes followed for both documents prior to publication.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1: Proposed policy approval route Appendix 2: Draft Corporate Policy Management Policy	

REVISED POLICY MANAGEMENT PROCESS

1 PURPOSE

The purpose of this report is to provide the Audit Committee with an overview of the revised policy management process within the Health Board, following the previous update provided on 29th October 2025. It outlines the rationale for change, highlights the key improvements made to streamline and clarify the management of corporate policy-related documents.

The report also summarises interim changes already implemented, the categorisation of corporate versus local documents, and the next steps for consultation and implementation to ensure compliance, consistency, and improved engagement across the organisation.

2 INTRODUCTION

At present, some policies, procedures and other written control documents (WCDs)[1] held on the Health Board's Policy Management System on BetsiNet are potentially no longer appropriate or relevant, with many not having been reviewed for a number of years, and therefore breach the current Health Board policy around the management of policies (*Policy for the Management of Health Board wide Policies, Procedures & other Written Control Documents,* herein referred to as '*Corporate Policy Management Policy'*), herein referred to as the 'Policy on Policies'.

The current process around the management of policies, procedures and other WCDs in the Health Board is not fit for purpose, and is a contributing factor to the current state of policy-related documents[2] being overdue a review. The current process is seen as laborious and cumbersome, and lacks clarity. In order to make improvements to ensure compliance, the Statutory Compliance Team has undertaken an initial consultation throughout the Health Board to revise and introduce a new, more streamlined and user-friendly process.

As part of this review, revisions were required to the '*Policy for the Management of Health Board wide Policies, Procedures & other Written Control Documents*', as well as the introduction of a Procedure, which details the series of actions to be conducted when preparing policy-related documents. In addition, the categories of previously held policy-related documents were reviewed to ensure that the correct types of corporate document are centrally held.

[1] The term 'written control document' is used to describe protocols and guidelines.
[2] The term 'policy-related document' will be used as the collective name for policies, procedures and other WCDs.

3 INTERIM PROCESS CHANGES

In the short term, and whilst the full consultation and approval process takes place, the Statutory Compliance Team have made some interim changes to simplify the process and reduce the workload for those preparing or reviewing policy-related documents, and to introduce a more robust process to ensure compliance. Much of the interim changes made feature in the new process and revised 'Policy on Policies', and the feedback around these interim changes has been extremely positive. Due to this, there is much more positive engagement around the Health Board's management of policies, which will assist in the implementation of the new process.

4 CORPORATE POLICY-RELATED DOCUMENTS

At present, there is a mixture of both 'corporate' and 'local' policy-related documents held on the Policy Management System on BetsiNet. As part of the new process, only Corporate or Health Board-wide policies, procedures and other WCDs will be included within the 'Corporate Policy Management Policy' and therefore retained on the Policy Management System, whereas 'local' policy-related documents will need to be stored and managed locally.

A Corporate or Health Board-wide policy, procedure and other WCDs are those that relate to:

- more than one directorate or division or department across the Health Board
- one directorate/department that spans more than one physical location
- relate to the direct or indirect treatment and/or impact on our patients
- where there could be wider impact on the whole organisation.

If a document relates to any kind of treatment of, or contact with, a patient, it should be classed as a 'corporate' document, whether it relates to one speciality, department, division or not.

4.1 'Local' Procedures

A 'local' document would relate to a department only standard operating procedure (SOP), protocol or guideline, which sets out the requirements for a specific department and does not have wider implications across the Health Board, or where other areas of the Health Board do not need to be made aware of its existence. If there is a requirement for a number of individuals to access this documentation across the Health Board, it is suggested that this is a 'corporate' rather than 'local' document. Examples of such documents include SOPs explaining an internal process such as dealing with mail, or an internal process around dealing with queries.

It will be the responsibility of the lead Executive Team Member of local procedures or SOPs not subject to the new Health Board process to determine the appropriate approval and scrutiny process for those documents.

5 POLICY-RELATED DOCUMENT DEFINITIONS

5.1 Current policy-related documents

The current 'Policy on Policies' requires that the following documents are held centrally on the Policy Management System, and published on BetsiNet:

- Strategy
- Policy
- Protocol
- Procedure
- Guideline
- Standards
- Cognitive Aids

5.2 Proposed policy-related documents

It is proposed to reduce this to the following corporate policy-related documents – these can be clinical or non-clinical in nature:

Corporate Policy	A written statement of intent, describing the broad approach or course of action that the organisation is taking with a particular issue eg compliance to legislation. Corporate policies affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.
Corporate Procedure	A standardised method of performing clinical or non-clinical tasks that is relevant organisation-wide. Corporate procedures affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.
Corporate Protocol	A written code of practice, including recommendations, roles and standards to be met, which can also include details of competencies and delegation of authority. Corporate protocols affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.
Corporate Guidelines	Give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with knowledge and expertise of the individual using them. Corporate guidelines affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.

6 POLICY-DOCUMENT TEMPLATES

As policies differ in the type of information and detail they contain to that of procedures and other WCD documents, there will now be two new templates – one for policies, and another for procedures and other WCDs.

7 CONSULTATION AROUND POLICY-RELATED DOCUMENTS

In the current 'Policy on Policies', there is an option to submit a draft policy-related document for Health Board-wide consultation. At present, issues do arise when Health Board-wide consultation has not taken place – this is a risk to the Health Board when certain elements have not been considered, which causes issues and delays, often much too late in the process, requiring changes to the documentation once final approval has been given. There are also occasions where the responsible Executive Team Member is not aware of the existence of a new or revised policy-related document assigned to their portfolio.

Therefore, within the revised process, it will be mandated that all policy-related documents are published in draft on BetsiNet for full Health Board-wide consultation, for a minimum period of two weeks, prior to the document being submitted for approval as per the approval routes detailed in the next section.

This will allow all interested parties an opportunity to review the draft documentation to ensure that it is fit for purpose and compliant before proceeding to approval and publication.

8 APPROVAL ROUTES

The current approval route, where policy-related documents are to be endorsed and approved is not clear, is causing confusion for policy owners, delays the process, varies across the Health Board, and contributes to the lack of engagement with the policy management process.

Even though the current policy approval process is a maximum of three steps, with only two approval steps for the majority of documents, the process is being overly delayed due to 'local' and often historical requirements for the review and approval of these documents – many take several months to follow this process before it reaches the mandated 'Policy on Policies' approval requirements. Due to this, the local requirements around approvals are distorting the perception of the Health Board's policy approval process, and is impacting the engagement of policy owners across the Health Board.

Please note that the new policy management process will not include requirements around any 'local' approval routes that a directorate or department wishes or is required to undertake prior to final approval – this will be at the discretion of the lead Executive Team Member, and is outside the scope of the revised process, 'Policy on Policies', and associated Procedure.

8.1 Proposed policy approval route

As mentioned above, policies are high-level documents, documenting the Health Board's written statement of intent, describing the broad approach or course of action that the organisation is taking with a particular issue, for example, to comply with legislation. These are therefore strategic documents that do not contain detailed processes and/or instructions, but set the overall policy statement and commitment for the issue, in line with the Health Board's strategic objectives.

Going forward, it is now proposed that all policies are approved by an Executive-led Group. The draft list of approval routes by category is provided in Appendix 1.

8.2 Proposed procedure and other WCD approval route

Unlike policies, these are detailed documents, which should be approved by specialist groups, where all the necessary clinical and/or other expertise are present so that the detail can be examined and tested prior to approval.

It is now proposed that all procedures and other WCDs are approved by specialist groups, as determined by the lead Executive. This detail has been provided to the Statutory Compliance Team by a combination of both the Executive Team Members and policy single point of contacts.

As with policies, there are certain areas within the Health Board where there is currently no clear route or reporting structure into a specialist group, therefore an interim proposal has been put in place.

9 ALL-WALES OR EXTERNAL POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS

All-Wales or external policy-related documents are those that are developed and collectively approved for adoption outside the Health Board.

9.1 Agreements to adopt all-Wales/external documents

The process around the adoption of these policy-related documents in the Health Board depends on whether there is an all-Wales or external agreement around how Health Boards should adopt such documents.

For example, the Welsh Partnership Forum (WPF) develops and reviews workforce policies on behalf of the partners by NHS Wales Employers. All Wales Policies developed and reviewed by the WPF form part of the agreed National Pay Terms and Conditions and therefore, organisations are required to implement them as they stand, with no variation. When this is the case, the policy-related document will not require any Health Board approval prior to implementation, with the relevant document being made available with all other policy-related documents on BetsiNet.

9.2 **Adoption of other all-Wales/external documents**

Where no such agreement is in place for other external/all-Wales policy-related documents, they will need to follow the Health Board approval route.

9.3 **All-Wales policy-related documents - Impact Assessments**

If an all-Wales or external EQIA or similar document has been completed on an all-Wales or external basis, the Health Board would still require a Health Board-specific impact assessment to be conducted to ensure that there are no adverse impacts from implementing the policy-related document. It will therefore be necessary to complete and seek approval of an EQIA and Impact Assessment Screening Tool for every external/all-Wales document to review the potential impacts on the Health Board. The lead Executive Team Member is responsible for reviewing and approving the EQIA and Impact Assessment Screening Tool, following consultation and approval of the content of these documents with the impact assessment leads eg Equalities Team.

A copy of the completed and approved EQIA and Impact Assessment Screening Tool document will need to accompany the all-Wales/external document when submitting to the Statutory Compliance Team.

9.4 **All-Wales policy-related documents for review**

At present, there are a number of all-Wales policy-related documents that are overdue a review, as per the timelines within the current 'Policy on Policies'. However, it is appreciated that the review of these documents is outside the Health Board's control.

It is therefore proposed that when an all-Wales or external policy-related document is due a review, where an updated all-Wales is not yet available:

- the current all-Wales document is reviewed, and if approved by the lead Executive Team Member, an extension of the review date granted, or;
- a new policy-related document is created by the Health Board until a revised all-Wales/external document becomes available, as per the process detailed earlier in this paper. This will need to follow the Health Board approval process.

This will be at the discretion of the lead Executive Team Member.

If an extension to an existing all-Wales/external document is granted, the approval of the lead Executive Team Member to be submitted to the Statutory Compliance Team so that the Policy Management System can be updated accordingly.

10 ‘POLICY ON POLICIES’ CONSULTATION

Once the above recommendations contained within this paper are approved by the Executive Committee and Audit Committee, the revised draft ‘Policy on Policies’ and associated Procedure will be updated if necessary, and published as a draft on BetsiNet for Health Board-wide consultation. Once this consultation has taken place, the documentation will be updated as necessary, and the ‘Policy on Policies’ and associated Procedure submitted through the current approval route. Once approved, the documentation will be published on BetsiNet, and the new process will be implemented.

A copy of the revised draft ‘Policy on Policies’ is included in Appendix 2.

11 POLICY MANAGEMENT SYSTEM

If the reduction in the policy-related document categories is approved, in line with Section 5, a number of current policy-related documents listed as for example ‘strategy’ will not be stored on the Policy Management System. The Statutory Compliance Team will liaise with the listed lead Executive Team Member to identify whether these documents are still valid, and discuss alternative options for storing these documents, as necessary.

12 COMMUNICATION AND ENGAGEMENT

The Statutory Compliance Team have already engaged policy owners/leads/contacts around the interim changes to the process, and this will continue with workshops, training videos and a refreshed Policy Management intranet page to assist those involved in creating new or reviewing existing policy-related documents.

All comments submitted by Executive Team Members following the last update to the Executive Committee have been considered, and the documentation amended as necessary.

13 DELEGATION OF AUTHORITY

If the Committee approves the revised approval routes (as per Appendix 1), work on updating the terms of reference for the relevant committees/meetings/groups will take place to ensure that there is clarity around the delegated responsibilities to approve such documents. This will be progressed by the Director of Corporate Governance.

14 BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this paper as it is for information only.

Resources for progressing the work around any policy-related work lies with the relevant directorate, division, or department as part of business-as-usual functions.

15 **EQUALITY AND DIVERSITY IMPLICATIONS**

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

However, as part of the work to revise the current ‘Policy on Policies’, and the creation of the new related Procedure, the Equality Impact Assessment and the Impact Assessment Screening Tool will be completed to identify any potential impacts.

POLICY APPROVAL ROUTE

1. Overarching responsibility

The Board is responsible for the approval of policy documents. This responsibility can be delegated to an appropriate Committee, Group or Forum in the Health Board in accordance with the Standing Orders, Reservation and Delegation of Powers, and will be one of the following:

- Approval reserved for the Board
- Approval delegated to a Board-level Committee
- Approval delegated to the Executive Committee

2. Board, Committees or Executive Group

The Board, Committees or named Executive Group is required to approve Policies, as detailed within the Health Board's Scheme of Delegation and Reservation. The Board will be responsible for the formal approval of the overarching Health Board Strategy, as well as policies that Committees, legislation or the Scheme of Delegation deem as requiring Board approval.

3. Executive Team Members

As detailed within the draft Policy Management Policy and associated Procedure, local, department only or single profession standard operating procedure (SOP), protocol or guideline, which sets out the requirements for a specific department or professional group, and does not have wider implications across the Health Board should be approved by the Executive Team Member of the responsible function. For further advice contact the Statutory Compliance Team, Corporate Governance Directorate

4. Scheme of Delegation

The Scheme of Delegation for the authorisation of policies, procedures and other written control documents is included on BetsiNet.

5. All-Wales basis

Where policies are created as a joint policy on an All-Wales basis or with partners and require formal adoption by the Health Board, the Board will delegate approval to the relevant Health Board Committee, as required.

6. NHS Wales Joint Commissioning Committee

Where policies relate to the functions of the NHS Wales Joint Commissioning Committee, the Board will delegate approval to the Joint Committee (JCC).

POLICY APPROVAL ROUTE

Whilst this is subject to change, the general rule of thumb for approval of policies, procedures and other written control documents is outlined the below table:

Subject area	Themes	Executive Group	Lead Executive Team member	Overarching Approving body
Statutory Legislative	Statutory/Legislative, for example Standing Orders, Standing Financial Orders etc	Executive Committee	Chief Executive	Board (require approval of the document by the relevant Committee prior to consideration by the Board
Governance	Corporate Governance Internal Controls Overarching Policy Framework Standards of Business Conduct	Executive Committee	Chief Executive	Audit Committee
Risk	Risk Management Framework (Board Assurance Framework and Corporate Risk Register)			
Emergency Planning	Emergency Planning			
Welsh Language	Welsh Language			
Legal	Legal			
Informatics	Informatics			
Counter Fraud	Counter Fraud			
Health records	Health records			Performance, Finance and Information Governance Committee
Subject access	Subject access			
Information governance	Information Governance			
Financial and Performance	Financial Management Performance Management Framework Joint Commissioning Committee Policies	Integrated Performance and Quality Group	Executive Director of Finance	Audit Committee

POLICY APPROVAL ROUTE

Governance – Charitable funds	for certain policies under Scheme of Delegation Investments Fundraising Bequests Donations	n/a	Executive Director of Finance	Charitable Funds Committee
Workforce (Staffing, equality and diversity)	Staffing Workforce matters including all-Wales human resource-related policies on behalf of the Board eg Welsh Partnership Forum Equality and Diversity	People and Culture Executive Group	Executive Director of Workforce and Organisational Development	People and Culture Committee
Health and Safety (including Estates)	Health and Safety Estates Environment	Strategic Health and Safety Group	Director of Environment and Estates	
Planning	Integrated Planning Framework (Integrated Medium-Term Plan / Annual Operating Plan and enabling strategies) Population Health improvement and inequality Strategic collaboration Partnerships Digital Capital and Estates Patient, public, staff, partnership and stakeholder engagement and co-production	Strategic Planning and Service Change Group	Interim Executive Director of Transformation and Strategic Planning	Planning, Population Health and Partnerships Committee
Remuneration Terms of service	Remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government, including contractual arrangements	n/a	Interim Executive Director of People Services and Organisational Development	Remuneration Committee

POLICY APPROVAL ROUTE

Quality Patient Safety Clinical Effectiveness	Quality Patient Safety Clinical Effectiveness Clinical governance Patient care-related Complaints Incidents Putting Things Right	Quality Executive Delivery Group	Executive Medical Director Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee
Mental Health Legislation	Compliance with the Mental Health Act 1983 (MHA) Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA)).	n/a	Executive Director of Allied Health Professionals and Health Science	Mental Health Legislation Committee

CORPORATE POLICY MANAGEMENT POLICY

Reference Number:		
Version Number:		
Policy Approved / Ratified by:	**Group Name**	**Date of meeting**
	Group	
	Delivery Group	
Date EQIA Completed:		
Date IAST Completed:		
Date of Next Review:		
Date of Publication:		
Link to Primary and Secondary Legislation, Ministerial Directions or Welsh Health Circulars etc:		
Group with authority to approve supporting procedures:		
Accountable Executive Director:	**Name**	**Role title**
	Pam Wenger	Director of Corporate Governance
Author(s):	**Name**	**Role title**
	Glesni Driver	Head of Statutory Compliance and Inquiries

CONTENTS

CORPORATE POLICY MANAGEMENT POLICY

1 POLICY STATEMENT

Having certain policies in place is a statutory requirement for NHS Wales bodies, but not every policy falls under statute. Some are legally required, some are mandated by Welsh Government/NHS Wales, and others are local 'best practice' or organisational governance tools.

1.1 Statutory Requirements

Under legislation such as the NHS (Wales) Act 2006, Health and Safety at Work Act 1974, Equality Act 2010, and other UK-wide/Welsh regulations, NHS organisations must have documented policies in certain areas, for example:

- Health and Safety Policy – required by the Health and Safety at Work Act
- Equality and Diversity/Equal Opportunities Policy – required by the Equality Act
- Data Protection/Information Governance Policy – required by UK GDPR and the Data Protection Act 2018
- Safeguarding Policies – required under the Social Services and Well-being (Wales) Act 2014
- Whistleblowing (Raising Concerns) Policy – statutory protection under the Public Interest Disclosure Act 1998
- Employment-related policies – some are rights (eg disciplinary, grievance, parental leave, flexible working).

These are statutory policies: NHS Wales organisations are legally obliged to have them.

1.2 Nationally Mandated NHS Wales Policies

NHS Wales also operates under an All-Wales Employment Policy Framework, agreed with Trade Unions, which standardises HR/employment-related policies across all Health Boards and Trusts. Examples are:

- Disciplinary Policy
- Grievance Policy
- Managing Attendance at Work Policy

While not all of these are statutory laws, they are mandatory under NHS Wales governance arrangements, so Health Boards must adopt them.

1.3 **Organisational (Local) Policies**

Beyond statutory and mandated policies, individual NHS Wales organisations develop local policies to support governance, safety, and consistency, eg:

- Medical device management policies
- Infection prevention and control protocols
- Risk management policies
- Policy for policy management

These are not statutory in themselves, but they demonstrate good governance and compliance with overarching statutory duties (eg duty of quality, duty of candour, duty of safety under the Health and Social Care (Quality and Engagement) (Wales) Act 2020).

1.4 This Policy will ensure that Betsi Cadwaladr University Health Board (BCUHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently in relation to its management of Policies, Procedures and other written control documents.

1.5 The Health Board has a statutory duty to ensure that appropriate policies (supported by procedures and other control documents) are in place in order to comply with legislation and regulation. Having effective, up to date and accessible corporate Policies, Procedures and other written control documents also helps to promote governance best practice, guide staff and minimise risks.

1.6 This Policy describes the Health Board's guiding principles that underpins decisions, behaviours and actions for everything we do.

1.7 Procedures and other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities.

1.8 A Corporate Policy, Procedure and other written control documents are those that relate to more than one directorate or division, and where there is a wider impact on the whole organisation.

2 POLICY COMMITMENT

2.1 Our Policies, Procedures and other written control documents will be in keeping with the organisational Values and Behaviours Framework.

2.2 Our documents will be written in plain language so that all staff, stakeholders and where appropriate people using our services, are clear about what is expected.

2.3 It will be possible to find them easily on our internet and/or intranet sites. Each document will have a lead Executive Director who has responsibility for making sure that it is regularly reviewed and kept up to date.

2.4 All impact assessments will be completed for all Policies, Procedures and other written control documents. This includes an assessment of the impact upon the Welsh language. Policies, Procedures and other written control documents will not be approved without a completed Impact Assessment Screening Tool (IAST).

2.5 Where a procedure or other written control document has been developed in support of a policy, it may not be necessary to undertake a further IAST if the impact is assessed to be the same. In this instance, the IAST for the policy must be referenced in the procedure/ other written control document. This will have to be confirmed in discussion with the impact assessment leads within Equality, Welsh Language etc.

2.6 All Policies, Procedures and other written control documents held on the Corporate Policy, Procedure and other written control documents Register will be published on BetsiNet, and will be provided in both English and Welsh language.

2.7 Our staff and stakeholders will be actively consulted during the development of all policies (and where appropriate procedures and other written control documents).

2.8 With regard to Workforce Policies, Procedures and other written control documents, engagement with the Trade Unions is welcomed. All Workforce Policies should be considered by Trade Unions via the Local Partnership Forum prior to formal approval.

2.9 There will be clear and appropriate approval mechanisms that reflect the scope and content of the document.

2.10 The Corporate Governance Directorate will provide central management of the Corporate Policy, Procedure and other written control documents Register and monitor compliance with this policy.

3 SUPPORTING PROCEDURES AND WRITTEN CONTROL DOCUMENTS

3.1 This Policy will be supported by the Corporate Policies, Procedures and Other Written Control Documents Management Procedure.

3.2 Other supporting documents are:

- The Health Board Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation
- Other policies and procedures, as required
- Records Management Policy (IG01)
- Corporate Records Management Procedure (IG02)
- Impact Assessment Screening Tool (IAST) (OBS06)
- Integrated Equality Assessment (WP7).

3.3 The IAST and Integrated Equality Assessment have been completed, and include details relating to both this overarching Policy and its related Procedure.

4 SCOPE

4.1 All employees must follow this Policy and related procedures and/or other written control documents.

4.2 This Policy is applicable to all employees with responsibilities for the development of BCUHB corporate policies, procedures and other written control documents.

4.3 This includes permanent, contracted or temporary staff of every grade, within every specialty and role.

4.4 Details of the process around the approval to implement all-Wales Policies and Procedures are contained within the *'Procedure on the Management of Corporate Policies, Procedures and other Written Control Documents'*.

5 IMPACT ASSESSMENTS

5.1 The Equality Impact Assessment (EqIA) form has been completed, and no impact found in relation to any of the areas contained within that document.

5.2 In addition, the Impact Assessment Screening Tool (IAST) has also been completed, and again no impact found in relation to any of the areas contained within that document.

5.3 The rationale for this is that this Policy is a document which describes the Health Board's commitment to ensuring that it delivers its aims, objectives, responsibilities and legal requirements transparently and consistently in relation to its management of Policies, Procedures and other written control documents only.

5.4 However, each Policy that is created as a result of this Policy may need to consider the different potential impacts.

6 TRAINING

6.1 There are no training implications as a result of the introduction of this review Policy.

6.2 However, the Compliance Team within the Corporate Governance Directorate will ensure that there is familiarisation of the revised processes as part of their business-as-usual duties.

7 RESOURCE IMPLICATIONS

7.1 There are no resource implications relating to the implementation of this Policy.

8 MONITORING AND ONGOING REVIEW OF POLICY

8.1 The Corporate Governance Directorate will undertake periodical and ongoing reviews of the Policy to ensure its continued suitability, and compliance to all legislative and regulatory requirements.

9 REVIEW PERIOD

9.1 This document will be reviewed in no more than 3 years from date of publication.

10 SUMMARY OF REVIEWS / AMENDMENTS

Version number:	Date of Review:	Date of Approval:	Date published:	Summary of Amendments / Changes:
0.01	02/04/2025			Total re-write of the DOCG01 - 'Policy for the Management of Health Board Wide Policies, Procedures & Other Written Control Documents' due to complete process change
0.02				Updates following review by Compliance Team: Removal of duplication re: 'documents to be read in conjunction' Change of wording in relation to staff/employees
0.03	02/09/2025			Updated information in relation to statutory requirements around policies in the 'Policy Statement' section
0.04	27/10/2025			Updated to include comments from: Assistant Director of Compliance and Business Management Interim Executive Director of People Services and Organisational Development

11 DISCLAIMER

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by searching:

- **Policies section of BetsiNet**
- **Contacting the Document Author**
- **Or the Corporate Governance Directorate**

This is a controlled document, the master copy is retained by the Corporate Governance Directorate

We do not encourage printing as the electronic version posted on BetsiNet is the master copy. Any printed copies of this document are not controlled.

This document should **not** be saved onto local or network drives but should always be accessed from BetsiNet.

Teitl adroddiad: ***Report title:***	Board Assurance Framework
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide assurance to the committee on the progression of the Board Assurance Framework (BAF) risks. The Board Assurance Risks were developed by the Board in October 2024, aligned to the Health Board's five strategic objectives within the Integrated Medium-Term Plan (IMTP). These risks are recognised as due for review. Once the 10-year strategy has been finalised, the Board Assurance Framework (BAF) will be refreshed and realigned to reflect the longer-term strategic direction. The BAF has been updated bi-monthly by Executive leads and reported to the Executive Committee, with the last formal review by Board Committees in April 2025 and presentation to the full Board in May 2025, in line with the Risk Management Framework. During the Strategic Risk Register Development Sessions held with the Executive Committee in July and August 2025, it was agreed that the next iteration of the BAF should remain a high-level tool focused on strategic risks scoring 15 and above. Key highlights include: • Proposed for Closure: As part of this rationalisation, one BAF risk which is currently assessed as medium is proposed for closure, BAF24-01 'Not Fully Building an Effective and Accountable Organisation'. This approach was endorsed by the Executive Committee development sessions (July and August 2025) and the Risk Scrutiny Group in November. The rationale being the majority of gaps in controls are now controls, several actions completed and open actions are duplicated in the new corporate risk CRR25-08 Regulatory non-compliance and can be monitored by the Board through the Corporate risk report. • Increase from 16 to 20: BAF24-07 Not Delivering Timely Access to Care Resulting In

<table>
<tr><td></td><td colspan="3">Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk
• Action Plan Progress: In total, seven actions (9%) are delayed and five of these actions are linked to digital team capacity. The majority of actions are either progressing (50%) or noted as completed (40%).

The assurance ratings have been approved by individual committees responsible for the risk. The Risk Scrutiny Group holds a deep dive on each BAF risk monthly for oversight. The Risk Scrutiny Group held a deep dive on:
1. BAF24-03 (2) ‘Inadequate Capital Investment to Support Organisational Change’

The Board Assurance Framework, as per cycle of risk reporting, bi-annually to the Board, next BAF report in full to the Board Jan 2026.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="3">The Committee is asked to:

• To receive and consider the contents and assurance rating of the Board Assurance Framework.
• Note the Board Assurance Framework actions will be further refined once all updates are received on the three year plan within the portal. The revised version will include key actions to reduce the risk, any actions where low confidence is noted and any other risks noted within the delivery of all the objectives associated with the IMTP.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="3">Pam Wenger, Director of Corporate Governance</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="3">Nesta Collingridge Head of Risk Management</td></tr>
<tr><td>Pwrpas yr adroddiad:

Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td>I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☐</td></tr>
</table>

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*** **N/A**	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	Not applicable for this report

In accordance with WP68, has an SEIA identified as necessary ben undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Board Assurance Framework paper
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Risk Scrutiny Group feedback 11/11/2025. The Risk Scrutiny Group held a deep dive on the ‘‘Inadequate Capital Investment to Support Organisational Change’ risk. Members suggested updates on the actions in the associated corporate risks to reduce the duplication between the two reports ensuring the corporate risk is safety focused but the BAF actions were correctly reflected as strategic. The Risk Scrutiny Group supported the closure of BAF risk ‘‘Not Fully Building an Effective and Accountable Organisation’, with some operational actions now

	duplicated in the newly approved Corporate risk 25-08 'Regulatory Non-Compliance' and will be able to be monitored within this risk. The Risk Scrutiny Group did not support the closure of BAF risk BAF24-05: Not Engaging with Citizens, Partners and Communities, rather provided feedback on the actions, which have since been updated for this report.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Board Assurance Framework risks linked to revised corporate risks
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable for this report

Camau Nesaf:

Next Steps:

1. Board session to set Strategic Objectives following this approval the BAF will be review and realigned to new objectives
2. Delayed risk actions to be monitored.
3. The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
4. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Committee, monitoring of actions within risks. Reporting to Committees quarterly and Board bi-annually as per Risk Management Framework.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 – Full Board Assurance Framework

Board Assurance Framework

Board Assurance Framework Report

1.0 Purpose

The Board Assurance Framework (BAF) serves as a strategic tool, designed to support the Health Board (BCUHB) in achieving its overarching goals and objectives. The BAF provides a structured approach for identifying, managing, and mitigating risks that may impact the successful delivery of our strategic priorities. Through clear alignment with our organisational strategy and key initiatives, the BAF enables us to maintain an accountable, transparent, and proactive approach to risk management.

The purpose of this BAF is threefold:

- To provide assurance that effective controls are in place to manage risks to our strategic objectives.
- To support informed decision-making by presenting clear, current risk insights to the Board and stakeholders.
- To align risk management efforts across the organisation, ensuring consistency with our vision of delivering high-quality, accessible healthcare services.

By integrating the BAF with our strategic priorities and operational plans, we can ensure that our risk management efforts directly support our mission to improve health outcomes, enhance patient safety, and foster a culture of accountability within BCUHB.

The purpose of this paper is to seek the Board's agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, following review by the Committee's responsible for the risks.

Board Assurance risks were developed by the Board based on the Health Board's 5 strategic objectives within the IMPT. Once the 10-year strategy has been developed the BAF will be reviewed and re-aligned to the longer-term strategy. The BAF was approved by the Board on 30 January 2025 and will be subsequently updated by action handlers and Executives on an on-going basis. The Board Assurance Framework has been updated bi-monthly by Executives and presented to the Executive Committee but last reviewed by the Board Committees in April and presented to the Board in full in May 2025. As per the Risk Management Framework.

1.1 Key Highlights

The full Board Assurance Framework was reviewed and updated by each responsible Executive and presented to the Risk Scrutiny Group during the November 2025 meeting, and following review and approval by the Executive Committee will be reported as usual

reporting cycle to Board Committees and presentation to the Board during the January 2026 Board meeting.

- BAF24-07 Not Delivering Timely Access to Care Resulting in Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk- Remains to have 'unsatisfactory assurance'.
- The Risk Scrutiny Group held a deep dive on the ''Inadequate Capital Investment to Support Organisational Change' risk during the November meeting. Members suggested updates on the actions in the associated corporate risks to reduce the duplication between the two reports ensuring the corporate risk is safety focused but recognised the BAF actions were correctly reflected as strategic.
- One BAF risk is proposed for closure, BAF24-01 'Not Fully Building an Effective and Accountable Organisation'. This approach was endorsed by the Executive Committee during the development sessions and subsequently endorsed by the Risk Scrutiny Group in November.
- This Risk Scrutiny Group reviewed low scoring risks for closure and provided feedback in relation to BAF24-05 'Not Engaging with Citizens, Partners and Communities', and has since been updated and an additional action identified 'Communications and engagement plan November 2025 to post Senedd election 2026 addressing progress to date and areas of Board focus in the months ahead'.

1.2 Changes in Score

Following further discussion at the Executive Committee, it was proposed 'BAF24-07 Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk' should increase from 16 to 20, reflective of the Corporate risk 'CRR25-01Timely Access' and development session presented to Board on Urgent and Emergency Care system pressures.

1.3 Risks above Health Board appetite

Five out of the eight threats are highlighted in the dashboard continue to be above tolerance

Ref	Title	Lead Exec Director	Current Risk Score (and IxL)
BAF24-02	Not Delivering Strategic Development and Digital Transformation	Executive Director of Transformation and Strategic Planning & Chief Digital & Information Officer	20
BAF24-03	Not Achieving Long Term Financial Sustainability	Executive Director of Finance	20
BAF24-04	Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Interim Executive Director of People Services and Organisational Development	16
BAF24-06	Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Executive Director of Nursing and Midwifery	20

		Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	
BAF24-07	Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Chief Operating Officer	20

1.4 Risks Proposed for Closure

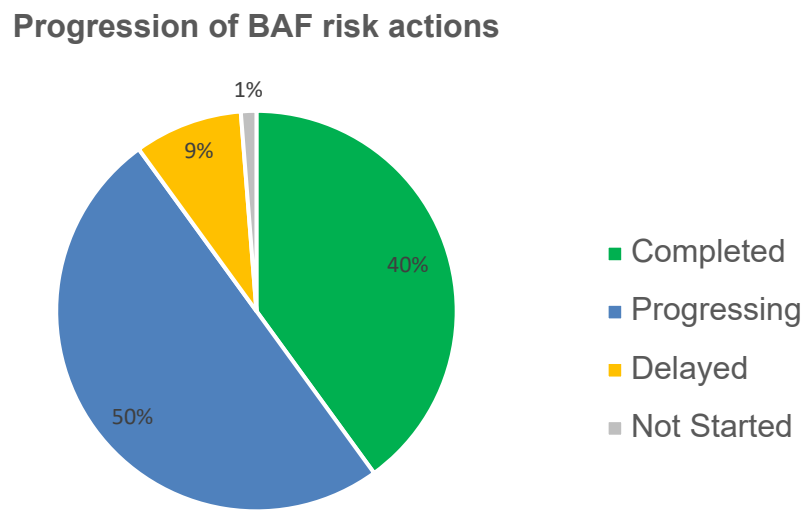
BAF24-01 Not Fully Building an Effective and Accountable Organisation, Director of Corporate Governance; score of 12. Noting, several closed actions, gaps in controls resolved and noted as new controls. Furthermore, some operational actions are now duplicated in the newly approved Corporate risk 25-08 Regulatory Non-Compliance and will be able to be monitored within this risk.

Ref	Title	Lead Exec Director	Current Risk Score (and IxL)
BAF24-01	Not Fully Building an Effective and Accountable Organisation	Director of Corporate Governance	12

1.5 Progression of BAF risk actions

Over a third of BAF actions have been completed since the last report to the committee, demonstrating good progress. Minimal revised actions. The digital team continue to present a number of delayed actions within their risk and have since presented this to the Risk Scrutiny Group, Executive Committee and to the relevant Committee.

In total, **seven actions (9%) are delayed** and five of these actions are linked to digital team capacity. The majority of actions are either progressing (50%) or noted as completed (40%). Completed actions will be archived in the following report for brevity.



By way of assurance on escalation the corporate team are assigned all risks in the planning portal and therefore will be able to monitor delays, blocks, low confidence and risks through the IMTP portal.

Next Steps

- Board session to set Strategic Objectives, following this approval, the BAF will be reviewed and re-aligned to new objectives
- Delayed risk actions to be monitored. Completed actions to be archived.
- The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Committee (bi-monthly) and Committees (quarterly) and Board (bi-annually) as per the Risk Management Framework.

Appendix

1. Appendix 1 – Board Assurance Framework October 2025.

Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Health Board's (HB) risk framework (with corresponding corporate and operational risks)
- Risk ratings – current (residual), tolerable and target levels. Risks are scored in line with the HB approved scoring matrix.
- Clear identification of strategic threats and opportunities that are considered likely to increase or reduce the Strategic Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (Averse = aim to avoid the risk entirely; Minimal = insistence on low-risk options; Cautious = preference for low risk options; Open = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment identified for each threat and opportunity, each assigned to a Risk Lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate: (1) Management (those responsible for the area reported on); (2) Risk and compliance functions (internal but independent of the area reported on); and (3) Independent assurance (Internal audit and other external assurance providers).
- Unlike corporate risks where target dates are key for mitigation, risks will remain reported as the Board seeks assurance accordingly until the risk is sufficiently mitigated. Actions are based on quarters for the year.
- Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating.
- The RACI clarifies roles and responsibilities for tasks and deliverables and is utilised for sub-risks however the responsibility of the overall BAF risks lies with the **Executive Team** and accountability lies with the lead committee.

Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)

Key to lead committee assurance ratings:

 **Substantial Assurance**	The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.
 **Reasonable Assurance**	The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.
 **Limited Assurance**	The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.
 **Unsatisfactory Assurance**	The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High

Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

This BAF includes the following Risks to the HBs strategic priorities:

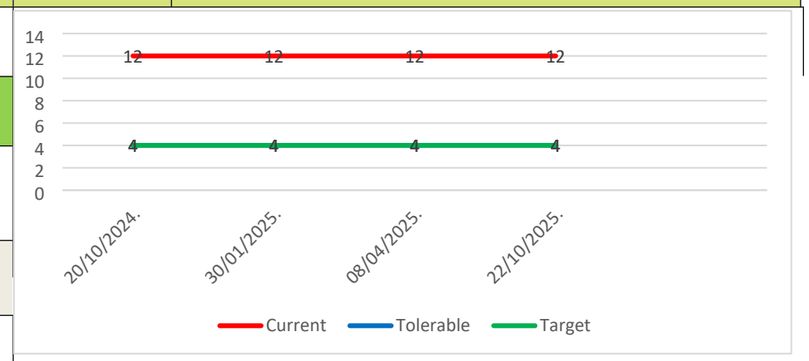
Reference	Principal risk: There is a risk of…	Lead Executive	Lead Committee	Initial date of assessment	Last reviewed by Executive SRO	Previous risk score (at previous review/update) C x L	Current risk score C x L	Target risk score C x L
BAF24-01	Not Fully Building an Effective and Accountable Organisation	Director of Corporate Governance and Executive Team oversight	Performance, Finance and Information Governance	20/10/2024	22/10/2025	4x 3= 12	**4x 3= 12**	2x 2= 4
BAF24-02	Not Delivering Strategic Development and Digital Transformation	Interim Executive Director of Transformation and Strategic Planning & Chief Digital & Information Officer	Planning, Population Health & Partnerships	20/10/2024	21/10/2025	5x 4= 20 **Above Tolerance**	**5x 4= 20**	3x 3= 9
BAF24-03	Not Achieving Long Term Financial Sustainability	Executive Director of Finance	Performance, Finance and Information Governance	20/10/2024	01/10/2025	5x 4= 20 **Above Tolerance**	**5x 4= 20**	3x 3= 9
BAF24-04	Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Interim Executive Director of People Services and Organisational Development	People & Culture	20/10/2024	03/11/2025	4x 4= 16 Above Tolerance	**4x 4= 16**	4x 2= 8
BAF24-05	Not Engaging with Citizens, Partners and Communities	Director of Partnerships, Communications and Engagement	Planning, Population Health & Partnerships	20/10/2024	21/10/2025	2x 3= 6	**2x 3= 6**	2x 2= 4
BAF24-06	Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Executive Director of Nursing and Midwifery Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	Quality, Safety and Experience / Planning, Population Health & Partnerships	20/10/2024	03/11/2025	5x 4= 20 **Above Tolerance**	**5x 4= 20**	5x 2= 10
BAF24-07	Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Chief Operating Officer	Performance, Finance and Information Governance	20/10/2024	30/10/2025	5x 4= 20 **Above Tolerance**	**5x 4= 20**	4x 2= 8

BAF24-08	Not Implementing Evidenced Based Improvement and Innovation	Executive Medical Director & Chief Digital & Information Officer	Planning, Population Health & Partnerships	20/10/2024	29/10/2025	4x 3= 12	**4x 3= 12**	4x 2= 8

1: Building an effective organisation

Objective area 1 recognises the importance of governance and effective procedures and decision making in high functioning Healthcare organisations. This will better ensure that decisions are made in a timely way, using appropriate information, and that the right people have been involved to ensure the right decisions are made first time.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-01: Not Fully Building an Effective and Accountable Organisation** Ineffectively delivering interconnected governance, operational, performance, and legislative challenges that could impede the Health Board's ability to develop a high-functioning, accountable, and cohesive organisation.		**Strategic objective**	1. To Build an Effective Organisation (1A & 1B: Governance (Board Effectiveness / Risk Management) 1C Operating Model; 1D Performance and Accountability Framework;1F: Legislative Improvements)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Compliance/Regulatory	
Risk Lead	Director of Corporate Governance with Executive Committee Oversight	**Risk appetite**	Open <15	
Related Corporate Risks:	CRR25-08, Non-Compliance with Regulatory and Legislative Requirements; CRR25-10, Health and Safety			



Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	4	2	**Initial date of assessment**	20/10/2024
Likelihood	3	2	**Last reviewed by Committee:**	12/08/2025

Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

Risk rating	12	4	**Last updated by Executive:**	22/10/2025	**N.B. Tolerable and Target score lines stacked as both are 4.**

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible: Head of Statutory Compliance and Inquiries/Assistant Director of Occupational Health, Safety And Security/ EPRR Lead		Accountable: Executive Committee			
Threat: the HB may not be compliant. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively.	• Health and Safety Policy • HS03 General Risk Assessment Procedure • HSG65 Plan, Do, Check, Act process for continuous improvement • Service Sector Health and Safety Self-Assessment and Health and Safety Reviews • Security Assessment of Premises • Some Civil Contingencies and Emergency Preparedness plans • Annual emergency preparedness evaluations improvement	• Remaining gaps in civil contingency planning post-pandemic • Incomplete integration of HSE recommendations into operational plans	**Management:** Health and Safety compliance reporting to Strategic Occupational Safety and Health Group (SOSHG) Monthly reviews of Health, Safety and Security KPIs **Risk and compliance:** Risk Register reporting but noted gap on the Gap analysis reporting for compliance and gaps of general legislative gap analysis. System in development. **Independent assurance:** • HSE audit and compliance checks • Civil Contingencies Act compliance review	• Gap analysis reporting general legislative gap analysis • Limited Assurance Internal Audit report for Health and Safety & Corporate Legislative Compliance. Improvement action plan in place and monitored at SOSHG.	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Approval and progression of the gap analysis for health and safety measures as set out in the updated Health and Safety Strategy and Plan 2024-2026 dated September 2024.	Head of Health, Safety and Security	Complete	30/09/2024
New approach for Health and Safety Management System being developed aligned to NHS Employers Health and Safety Standards, to include Violence Prevention and Reduction Standards	Head of Health, Safety and Security	Progressing	31/12/2025

Responsible:	Director of Performance and Commissioning	Accountable:	Director of Corporate Governance/CEO

Appendix 1 – Board Assurance Framework October 2025.

Threat: the Performance and Accountability Framework may not effectively establish clear lines of accountability and provide consistent, real-time performance monitoring. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively.	• Integrated Performance Framework • Integrated Performance reports aligned • Clear accountability matrix and escalation for senior and mid-level management • Performance scorecards for service delivery units	• Inconsistent application of performance tools across departments • Review Integrated Performance Framework to re-align with new strategic objectives Triangulation with risk management	**Management:** • Reviews of performance metrics at Executive Team level • Regular reporting to Committees **Risk and compliance:** • Monthly accountability reviews if in escalation for services SLT • Performance Reviews held by the CEO • Monthly performance reviews by Welsh Government **Independent assurance**: • External NHS Wales and Health Boards performance benchmarking and NHS benchmarking network	• Reports on performance at IHC • Commissioning reports on out of area	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Review Integrated Performance Framework and finalise the redesign of reporting structures/timings to enhance transparency. Due to be updated ahead of March 2026 Board.	Director Of Performance	Progressing	31/03/2026
Improved Risk triangulation with concerning trajectories. Structural review completed, improvement plans to then be provided to specific directorates and divisions where they need to better integrate risk into planning, quality or performance. The risk team will complete this review as business as usual going forward as a part of Risk Audits.	Head of Risk Management	Complete	31/09/2025

Responsible:	Director of Corporate Governance	Accountable:	CEO

Threat: the Health Board's operating model may become inefficient or fragmented, leading to unclear roles, duplication of efforts, and siloed working. This could result in reduced operational effectiveness, slower decision-making, and diminished quality of care,	• Current definitions of operating model roles and structures in place • Business Partnering approach for clinical and corporate leadership • Staff co-producing a new Operating Model	• Delays in decision-making due to leadership duplication • Lack of integrated systems reducing efficiency • Service reconfiguration plans based on population health needs • Digital tools (Microsoft 365) to streamline operations	**Management:** • Service-level performance audits **Risk and compliance:** • Assessments of operating model efficiency and insight reports **Independent assurance:** • Operating model effectiveness review by internal and external stakeholders	• Limited Assurance Internal Audit report for Operating Model & Effective Governance (IHC) Central	**Limited Assurance**

Appendix 1 – Board Assurance Framework October 2025.

			• Internal Audit report on duplication of roles and decision-making timelines		

↑	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Completion of the discovery phase reviewing of the operating model based on stakeholder feedback	Programme Manager, Transformation & Improvement	Complete	30/11/2024
	Implement a streamlined decision-making protocol by Q3 and looking a re-design phase. Draft completed and out for consultation due for approval at Audit Committee Dec 2025 but design complete.	Director of Corporate Governance	Complete	31/10/2025
	Review of the Scheme of Delegation and establishment of a formal Executive Committee with reporting groups with clear delegations. Scheduled to for presentation at the next Audit Committee 11/08/2025 – paper presented to Executive Committee in August. Approved by the Board.	Head of Corporate Affairs	Complete	25/09/2025

Responsible:	Head Of Corporate Affairs/Head of Risk Management	Accountable:	Director of Corporate Governance

Threat: the Health Board's has weak Governance and Ineffective Risk Management Practices	• Governance and Accountability Framework, Risk Management Framework updated for improved escalation pathway to Risk Scrutiny Group. • Risk Appetite set 25/26 • Board Development Programme including self-assessments incorporating feedback • Internal Audit Tracking of Recommendations • Board committee structure now all in place • Policy oversight, tracking and reporting of overdue policies. • Risk Management training levels launched and all Risk Maturity Audits cycle in place with tracking of improvements	• Integrated Corporate Governance software for efficient regulatory, policy and risk tracking.	**Management:** • Risk reporting at local level and strategic level. **Risk and compliance:** • Risk reporting to the Executive Team and Committees Key Performance Indicators (KPIs) on risk management performance **Independent assurance:** • Internal Audit Reporting - Reasonable assurance with areas of substantial • Audit Wales Structured Assessment Report and other Audit Wales Reports	• Limited Assurance Internal Audit reports for: Review of Board Effectiveness & Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality • Audit Wales governance recommendations	**Limited Assurance**

↑	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Improved Scrutiny of Corporate Risks. & Development of the BAF	Head of Risk Management	Complete	30/01/2025
	Improved Data Analytics of Governance around Risk (Dashboard) and driving improvement of metrics. N.B This work will be ongoing now to ensure the KPIs remain in tolerance (risks being updated) and reported to Audit Committee quarterly.	Head of Risk Management	Complete	30/01/2025
	Reviewing current systems to have a more effective way of tracking and reporting audit recommendations. Corporate Governance (policies/tracking) /Risk Management and System to be approved for procurement 22/12/25, new software in	Head of Statutory Compliance and Inquiries	Progressing	30/09/2026

Appendix 1 – Board Assurance Framework October 2025.

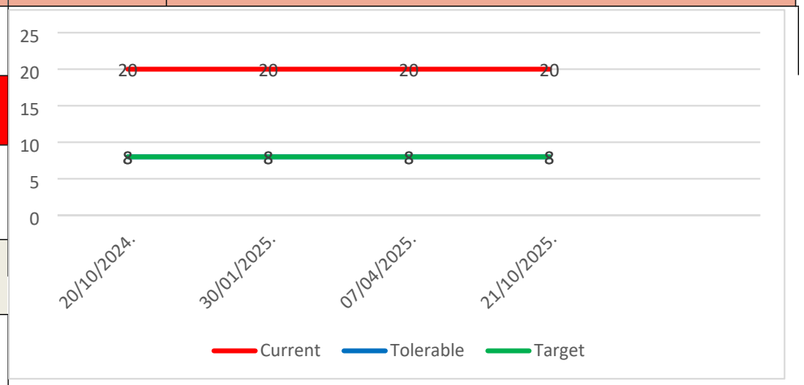
	place by 30/04/25 but piloted end of 2026 which will support automated tracking. This will not be embedded until 2026-2027.			
	Executive Team recruitment ongoing with some progress made on appointments. Director of People and OD in progress with interim arrangements in place	Interim Executive Director of People Services and Organisational Development	Progressing	31/03/2026

2: Developing strategy and long-lasting change

Objective area 2 draws upon the need for the Health Board to be clear about population needs in North Wales and that services are configured in a way to get the highest value from the resources available to us. In this way the Health Board can provide services that are reliable, more cost-effective, and that make the best use of healthcare professionals.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-02: Not Delivering Strategic Development and Digital Transformation** **There is a risk we won't achieve our strategic and operational objectives as a Health Board, caused by having inadequate arrangements and skills for identification, commissioning and delivery of Digital, Data & Technology enabled change.** **This will lead to an inability to deliver new models of care in line with national and local strategies, which results in a degradation in patient safety, quality of care, public confidence, financial controls and reputation** .	**Strategic objective**	2. Developing strategy and long-lasting change (2A 10-year Strategy & 2H Strengthening Planning; 2E Digital, Data, and Technology;)
Lead Committee	Planning, Population Health & Partnership Committee	**Risk type**	Quality
Risk Lead	Executive Director Transformation and Strategic Planning / Chief Digital & Information Officer	**Risk appetite**	Open <15 Risk Above Tolerance
Related Corporate Risks:	CRR25-05, Strategic Change – Impacting Care and Staff Delivery; CRR25-04, Modernising our Infrastructure		

Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	**5**	5	**Initial date of assessment**	20/10/2024



Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

Likelihood	**4**	2	**Last reviewed by Committee:**	21/08/2025
Risk rating	**20**	**10**	**Last updated by Executive:**	21/10/2025

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Assistant Director of Compliance and Business Management	Accountable:	Chief Digital & Information Officer		
Threat: the organisation may struggle to keep pace with the rapid evolution of digital, data, and technology innovations and have outdated systems, inefficiencies, and an inability to fully harness data for informed decision-making and personalised patient care by lack of investment in DDaT infrastructure due to competing priorities	• Cyber Security Plan (and evidenced of reasonable assurance through recent internal audit) • Plans to recruit key skills and capabilities gaps • Business case developed for Mental Health and Acute and Community Electronic Health Record (EHR) • Clear benchmarking with Gartner IT Score to assess and guide us on what we need to do. • Skills and capabilities augmentation contracts in place with third party companies to support the internal teams in delivering what is required	• Lack of recurrent funding and support the recruitment of critical roles • Lack of support to procure flexible augmentation contracts	**Management:** • Quarterly reviews of digital objectives including projects at service level to Senior Leadership Team • Performance and accountability meetings for Annual Plan objectives **Risk and compliance:** • Annual audit of data governance and cyber security measures • Corporate Risk in place **Independent assurance**: • Internal and external audits of data governance and technology • Information Commissioners office • Continual Benchmarking from Gartner Group and Service Desk Institute against best practice		**Limited Assurance**

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**

Appendix 1 – Board Assurance Framework October 2025.

↑	Senior Posts for reviewing Digital architecture and EHR. Funding for Architecture and EHR Teams is temporary and has been sourced from various non-recurrent budgets. Teams likely to have to stand down from April 2025 onwards and therefore progress halted (subject to budget setting process). NB. This is a 3-to-5-year piece of work. Activity which is required by 31st March 2025 will be completed.	Chief Technology and Information Officer	Delayed	31/03/2025
	Roll-out of key priority digital transformation projects. No funding from April 2025 onwards, to progress EHR Programme and other augmentation projects to improve the current digital environment. NB. This is a 3-to-5-year piece of work. The Electronic Health Record (EHR) – Acute and Community, Outline Business Case (OBC) first draft was handed over from the external consultants in March 25, the OBC has been updated following engagement with legal, finance, procurement and DDaT. Currently, there is no funding to progress this further, and Welsh Government have asked all Health Boards to pause while they agree a national approach. The Mental Health EHR is progressing with the procurement evaluation complete. Once assurance activities have been completed the next step will be to finalise the Full Business Case (FBC) and award contract following board approval.	EHR Programme Director (not in post)	Delayed	31/03/2028
	Transformation of the DDaT Operating Model. Lack of available recurrent funding has hampered this piece of work. Alternative solutions being explored using non-recurrent funding mechanisms, however due to significant gaps in current senior leadership and anticipated outcome from Foundations for the Future Programme, progress in this area has halted.	Assistant Director Of Compliance And Business Management	Delayed	31/03/2025
	Proposals, (repeated from previous years) for 2025/26 onwards are being progressed for consideration. Cost Pressures and Growth proposals submitted to Executive Team for consideration. Only RIGA 1 additional funding resource received which doesn't take into consideration the required cost pressures or growth initiatives. Will continue to review funding gaps and available schemes.	Assistant Director Of Compliance And Business Management	Delayed	31/03/2025

Appendix 1 – Board Assurance Framework October 2025.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Assistant Director of Health Strategy & Planning	Accountable:	Interim Executive Director of Transformation and Strategic Planning		
Threat: Lack of a relevant long term 10-Year Strategy and Clinical Services Plan that can be used to strategically guide our short to medium term plans.	• Ensure strategy development aligns with population needs assessments. • Prioritise internal and external stakeholder engagement, collaboration and co-production. • Integrated planning framework updated with learning from each planning cycle. • Alignment of finances, workforce and performance via the Planning process.	• Limited public engagement and stakeholder input at the early formative stages of strategy development and planning. • Effective mechanisms to prioritise resources to strategic priorities. • Integrated view of impact of plans, demonstrating which outcomes have improved for the population.	**Management:** • Annual review of planning cycle. • Annual Delivery Plan progress reports on strategy development milestones. **Risk and compliance:** • External benchmarking of planning effectiveness through the Planning Maturity Matrix. **Independent assurance**: • Independent review as part of special measures. • Welsh Government annual assessment of submitted IMTP.	• None identified at present	**Limited Assurance**

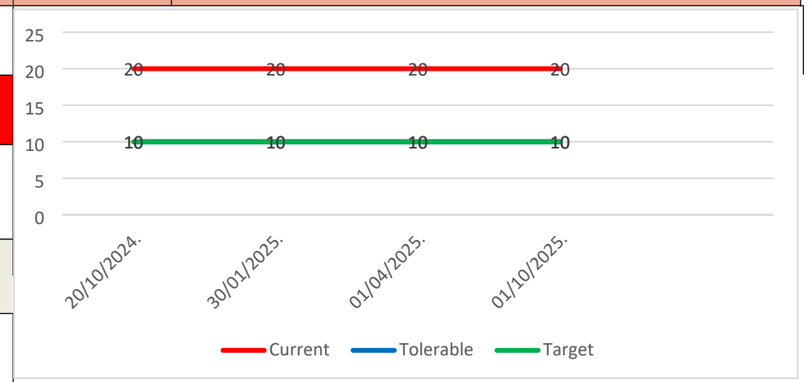
Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Strategic intent for North Wales to be developed with Partners in order to develop and deliver the 10-Year Strategy (subject to creating sufficient capacity in the Planning team to take this work forward).	Head Of Health Strategy And Planning	Progressing	30/12/2025
Implement phase 1 of Clinical Services Plans in relation to the Challenged Services	Assistant Director of Transformation and Improvement (Interim)	Progressing	30/03/2026
Develop phase 2 of the Clinical Services Plan for implementation - a blueprint for services across North Wales	Head Of Health Strategy And Planning	Not started	30/03/2027

Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-03: Not Achieving Long Term Financial Sustainability**			**Strategic objective**	2. Developing strategy and long-lasting change (2I Finance Governance Environment; 2D Capital Priorities: Supporting Change)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Finance		
Risk Lead	Executive Director of Finance	**Risk appetite**	Open <15 Risk Above Tolerance		
Related Corporate Risks:	CRR25-06 , Value Delivery and Financial Sustainability ; CRR25-09 , Safe Environment				

Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	5	5	**Initial date of assessment**	20/10/2024
Likelihood	4	2	**Last reviewed by Committee:**	12/08/2025
Risk rating	**20**	10	**Last updated by Executive:**	01/10/2025



Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps**	**Assurance rating**
Responsible:		Interim Director of Finance	**Accountable**:	Executive Director of Finance	
Threat: The financial climate is challenging, with no further allocations expected to offset adverse performance. The first financial duty is to attain a break-even financial position over a rolling three years period. In not achieving break even the organisation suffers; A regulatory breach from Failure to achieve the key duty results in a Qualification Failure to achieve breakeven places at risk future receipt of conditionally recurrent allocations and/or the ability to attract prospective allocations. Cash depletion and a potential lack of ability to pay employees and suppliers of goods and services. The Health Board will still be required to meet its statutory duty to break-even, resulting in a need to reduce costs and potentially reduce access to services offered to the local population.	• Annual Plan details requirements for further controls and required controls detailed in 'Gaps in controls' • Monthly reporting of financial performance, articulating risk to delivery, drivers of any financial risk and suggested actions in place to mitigate risk • Monthly reporting to Welsh Government financial performance each month, again articulating drivers of risk to delivery and mitigating actions • Corporate risk for shorter term sustainability in place • A key element of delivery centres upon savings realisation, the Value & Sustainability programme formed to support mitigation of shortfalls and place focus on improvements driving financial sustainability.	• Financial governance framework aligned with the organisation's strategic priorities • An endorsed Clinical Strategy that articulates demand and capacity modelling by speciality. • Financial capital resource availability • Integration of financial planning with performance and risk management processes • Whilst the Health Board has a balanced financial plan, this carries significant risk associated with continued opening of additional capacity areas and exposure to medicines and continuing healthcare rising costs. In addition, following endorsement of the financial plan, a number of significant risks have emerged from a movement from key planning assumptions. • Inconsistent alignment between financial planning and strategic service goals	**Management:** Monthly financial reporting and budgetary controls Oversight through Performance, Finance & Information Governance Committee **Risk and compliance:** Oversight by Audit Committee Annual audit of financial governance effectiveness (to include budgetary control) Regular financial performance reviews **Independent assurance:** Internal and external audit reports on financial controls Annual review of compliance with Welsh Government financial guidelines Audit Wales full access to mapping of financial transactions within financial statements to source ledgers Monthly oversight of financial performance by Welsh Government	Limited Assurance Internal Audit report for Delivery of Health Board Transformational Savings Value & Sustainability Programme launched to mirror the National models to place focus on savings delivery as a product of improvement with a track record of delivery Head of Internal Control Opinion articulating limited assurance over systems of internal control Positive assurance for budgetary control environment Audit Wales issued a "true and fair" audit opinion on the 2024/25 accounts but gave a Qualification for regulatory breach. Health Board attaining financial plan. No changes from draft accounts to final submission following External Audit scrutiny	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Implementation of Value Based Healthcare and a Value and Sustainability approach to savings development. Implemented and principle approach agreed, savings will be developed through Executive leads through transactional and transformational schemes.	Finance Director -	Progressing	31/03/2026

Appendix 1 – Board Assurance Framework October 2025.

		Commissioning & Strategy		
	Strengthen financial forecasting and integrate financial risks into operational planning. Progressing through IMTP production. Deep Dive process already in place with CFOS on a monthly basis	Finance Director - Commissioning & Strategy	Complete	30/09/2025
	Develop further the control environment for addressing planned position and implementation of any corrective actions. Additional control actions have been implemented to support the HB .	Finance Director - Commissioning & Strategy	Complete	31/03/2025
	Enhanced Accountability & Performance framework to hold officers to account for delivery. Areas for escalation have been identified and separate meetings held with services chaired by CEO.	Finance Director - Commissioning & Strategy	Complete	27/12/2025

Responsible:		Head Of Capital Development	Accountable:	Director of Environment and Estates		
Threat: Inadequate Capital Investment to Support Organisational Change	• Estates Strategy • Capital prioritisation programme aligned with strategic objectives that involves operational and clinical teams in prioritisation of limited resources • Project management for capital investments, the Health Board having substantial material schemes in train • Prioritisation of investments in infrastructure to support clinical services and statutory requirements • Capital Manual • Capital prioritisation for urgent projects • Six facet survey being completed for all provider infrastructure	• Delays in capital project approvals and implementation. • Delays in raising orders likely to impact project critical path. • End of year wrap up report on overheads and programme progress. • Implement stronger project management controls to track capital investments. • Discretionary capital use in prioritisation between medical equipment, IM&T and Estates works (relative prioritisation between asset classes not undertaken) • Prioritisation of substantial business cases within the plans of the Health Board that aligns to Clinical Strategy	**Management:** • Monthly financial reporting of plan verse actual expenditure and budgetary controls **Risk and compliance:** • Some reviews to assess the alignment of capital investments with strategic goals Board **Independent assurance:** • Internal Governance of capital project progress and expenditure and reporting up to Committee and Welsh Government. • Welsh Government monthly reviews of plans for expenditure in year verse allocated resources.	• Reports on alignment of capital investments with strategic goals Board • Prioritisation plans being endorsed through Executive for inclusion within the IMTP endorsed through Health Board and Committees. • External support secured to service major capital developments. • Capital Investment Group formed, reporting into Executive on Capital works.	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Decarbonisation Board reporting of key objectives through to Committee (PPHP) completed, articulating goals and objectives through to Health Board. Revised NHS Wales decarb plan due for review in 2025, once finalised the HB will produce and action plan.	Director of Environment and Estates	Progressing	31/03/2026
Ongoing development of Estates strategy to be informed by completion of six facet survey as well as the collection and validation of other data (review of estates which will take 12 months) to drive estate utilisation and rationalisation.	Director of Environment and Estates	Progressing	31/03/2026

Appendix 1 – Board Assurance Framework October 2025.

	Monthly reporting of this year's expenditure verse plans in order to ensure delivery of this year's capital programme, fully embedded and forms new control.	Executive Director of Finance	Complete	31/03/2026
	Prioritisation of major capital works within the strategy for the Health Board in completion of the three-year IMTP. Schemes and priorities discussed at Execs.	Assistant Director - Strategic And Business Analysis	Progressing	31/03/2026

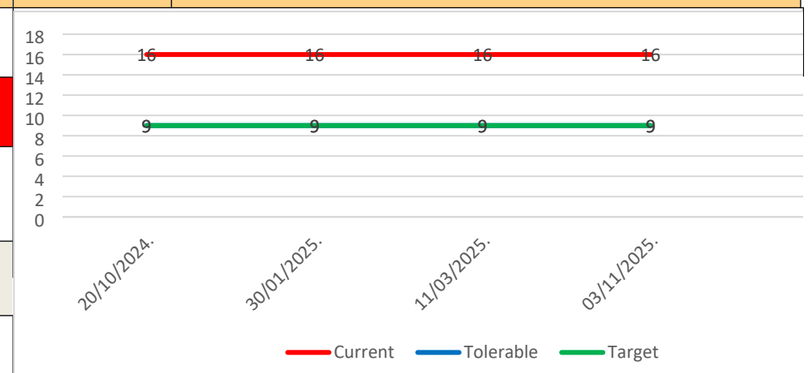
Appendix 1 – Board Assurance Framework October 2025.

3: Creating compassionate culture, leadership and engagement

Objective area 3 capitalises upon the huge body of evidence that demonstrates how culture, leadership and engagement with residents, staff, communities and partners significantly impact upon the quality of services and patient experience provided. The Health Board has identified opportunities to make improvements in these areas that would then in turn lead to better outcomes.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability** A risk that the Health Board may inadequately foster a compassionate culture and strong leadership, resulting in disengaged staff, low morale, and high turnover.			**Strategic objective**	3: To have a compassionate culture, leadership & engagement (3A Compassionate Leadership and Organisational Development & 1G Workforce Planning)
Lead Committee	People & Culture Committee	**Risk type**	Quality		
Risk Lead	Interim Executive Director of People Services	**Risk appetite**	Open <15 Above Tolerance		
Related Corporate Risks:	CRR25-02, Future Demand & Sustainable Workforce; CRR25-07, Leadership and Operating Model				

Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	4	4	**Initial date of assessment**	20/10/2024
Likelihood	4	2	**Last reviewed by Committee:**	14/08/2025
Risk rating	**16**	8	**Last updated by Executive:**	03/11/2025



Appendix 1 – Board Assurance Framework October 2025.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Head Of Policy, Practice & Compliance- WOD	Accountable:	Interim Executive Director of People Services		
Threat: that the Health Board may inadequately foster a compassionate culture and strong leadership, resulting in disengaged staff, low morale, and high turnover.	• Workforce Planning Framework in collaboration with HEIW • Skill-mix review and capacity-building programmes • Strategic partnership with Bangor University • Integrated Leadership Development Framework • Staff Engagement Plan • Continuous feedback loops for leadership performance • All Wales International Recruitment programme for nurses and doctors. • Improved Internal Audit Assurance with recruitment of senior and interim staff • Staff counselling / Occupational Health support • Strategic Equality Plan key driver in the culture change required for a compassionate and inclusive culture.	• Critical vacancies, particularly in clinical and leadership roles • Underdeveloped retention and progression pathways • Further embedding of Integrated Leadership Development Framework • Further leadership development initiatives • Current Equality governance arrangements require strengthening	**Management:** • Service Led skill-mix efficiency and commissioning requirements • Annual staff engagement surveys and reports to Committee and Board • People & Culture Dashboard to Committee **Risk and compliance:** • Corporate risks CRR24-01 People, Culture and Wellbeing CRR24-16 Leadership/Special Measures reported to committee. • Review of all Organisational Development risks reported. Local Workforce and Organisational Development risk meeting. • Quarterly performance reviews to CEO of Directorates/ Divisions • Freedom to Speak Up Guardian report **Independent assurance**: • Annual workforce plan reviews with HEIW • Internal Audit reports	• Limited Assurance Internal Audit report for Review of Workforce Planning Arrangements	**Limited Assurance**

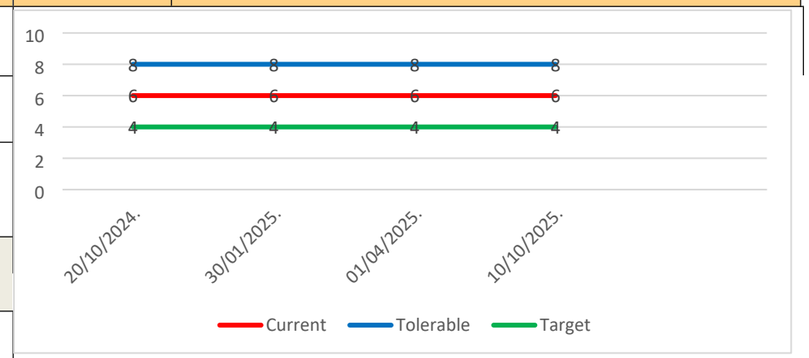
Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Prioritise workforce plans for ‘challenged services’	Interim Exec Director People and OD / Associate Director Workforce Optimisation	Progressing	31/03/2026
Continue reducing agency usage and improve value and sustainability of workforce	Interim Exec Director People and OD / Associate Director Workforce Optimisation	Progressing	31/03/2026
Implementing Values and Behaviours Framework	Interim Exec Director People and OD	Progressing	31/03/2026
Embedding Integrated Leadership Development Framework	Interim Exec Director People and OD	Progressing	31/03/2026

Board Assurance Framework (BAF): October 2025

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 1 – Board Assurance Framework October 2025.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-05: Not Engaging with Citizens, Partners and Communities** Risk of ineffective engagement with citizens, partners and communities may result in a lack of public trust, poor service user experience, and a disconnect between the Health Board's services and the needs of the population.			**Strategic objective**	3: To have a compassionate culture, leadership & engagement encompassing 3B: Citizen Engagement & 3C: Being a Good Partner
Lead Committee	Planning, Population Health & Partnership Committee	**Risk type**	Reputation		
Risk Lead	Director of Partnerships/Communications and Engagement	**Risk appetite**	Seek <25		
Related Corporate Risks:	CRR25-03 Population Needs				



Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	2	2	**Initial date of assessment**	20/10/2024
Likelihood	3	2	**Last reviewed by Committee:**	21/082025
Risk rating	**6**	4	**Last updated by Executive:**	10/10/2025

Appendix 1 – Board Assurance Framework October 2025.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Director Of Partnerships/communications And Engagement	Accountable:	Director Of Partnerships/communications And Engagement		
Threat: of ineffective engagement with citizens and communities may result in a lack of public trust, poor service user experience, and a disconnect between the Health Board's services and the needs of the population.	• Collaboration with key stakeholders • Strategic partnerships with local authorities and community organisations • Partnership governance frameworks • Comprehensive inclusive and diverse citizen engagement strategy • Accessible feedback mechanisms such as surveys and public engagement activity • Regular updates to the public on strategic priorities • Survey of engagement across the Health Board • Collaboration on complaint's process	• Communication back to the public on their influence from feedback • Lack of structured feedback from key partners • Limited cross-sector collaboration in specific service areas • Anchor Institute Framework	**Management:** • Citizen experience reports to Board • Feedback from engagement and where required public consultations. **Risk and compliance:** • Partnership feedback sessions • Forward Plan and oversight of Regional Partnership Board by the Planning, Population Health & Partnership Committee **Independent assurance**: • Perception survey with partners • Independent Advisor for external perspective on engagement approach	Risk Register for Partnerships/Communications and Engagement.	**Limited Assurance**

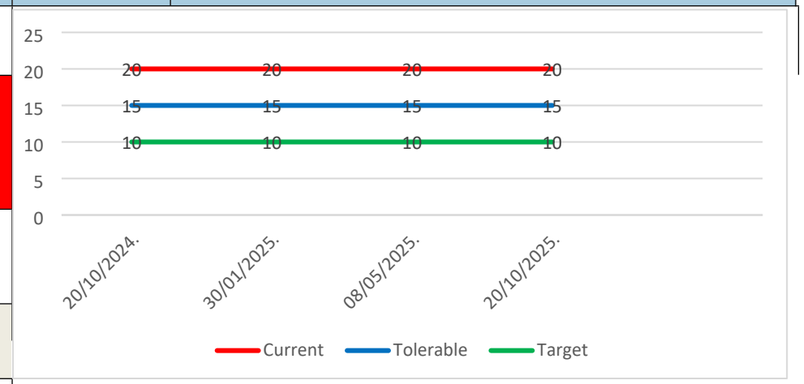
	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Perception Survey completed, Survey findings to now go to Executive Committee and PPHP Committee	Director Of Partnerships/ communications And Engagement	Complete	31/03/2025
	Developing Anchor Institute Framework – ongoing, with paper to Executives by 31/05/25 outlining approach and next steps	Director of Partnerships/ communications And Engagement	Progressing	31/03/2026
	Citizen Engagement Plan being reviewed – the draft principles and framework developed - now with the engagement group for comments	Director of Partnerships/ communications And Engagement	Progressing	30/06/2026
	Improve the feedback loop to ensure timely action on public input – ongoing, with review of Board actions against key themes by 31/01/25. January Citizen's Engagement report as evidence	Director of Partnerships/ communications And Engagement	Complete	31/01/2025
	Communications and engagement plan November 2025 to post Senedd election 2026 addressing progress to date and areas of Board focus in the months ahead – plan in development, overseen by the Chief Executive Officer	Director of Partnerships/ communications And Engagement	Progressing	31/05/2026

Appendix 1 – Board Assurance Framework October 2025.

4: Improving quality, outcomes and experience

Objective area 4 covers a large thematic area where improvements are required to improve clinical performance across a number of key areas. The Health Board wishes to build further upon good work commenced that takes a pathway focused approach to this.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes** Risk of ineffectively delivering consistent high quality of patient care across the HB resulting in incidents of avoidable harm and poor clinical unmet patient needs, regulatory non-compliance, and reputational harm.			**Strategic objective**	4. To Improve Quality, Outcomes and Experience (4A Patient Experience; 4B Prevention; 4I Adult Mental Health, Learning Disability)
Lead Committee	Quality, Safety and Experience Committee / Planning, Population Health & Partnership Committee	**Risk type**	Quality		
Risk Lead	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	**Risk appetite**	Open <15 Above Tolerance		
Related Corporate Risks:	CRR25-01, Timely Patient Access to Safe and Effective Care; CRR25-03, Population Needs				



Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	5	5	**Initial date of assessment**	20/10/2024
Likelihood	3	2	**Last reviewed by Committee:**	21/08/2025
Risk rating	20	10	**Last updated by Executive:**	20/10/2025

Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible: Deputy Executive Director of Nursing		Accountable: Executive Director of Nursing	Responsible Committee: Quality, Safety and Experience Committee		

Threat: A loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	• Integrated Concerns Policy and daily Hub meetings in place to review all concerns of moderate , grade4/5 and above
	• Patient incident/feedback systems and policies
	• Data analysis and learning at service level
	• Datix Reporting
	• Patient safety Staff training - Quality governance arrangements at Health Board, IHC/division & service levels including:
	  ○ Local ICOG and Exec EICOG Groups
	  ○ BCUHB patient safety, infection prevention , safeguarding and patient experience groups
	  ○ BCUHB SCEG, meetings
	  ○ Local and Exec Quality Delivery Groups
	  ○ Clinical audit programme & monitoring arrangements
	  ○ Ward accreditation/ metrics
	
	• Integrated Concerns Policy and Toolkit
	• Concerns Hub
	• Rapid review Sign-off process for incidents and Nationally Reported Incidents
	• Executive Led Oversight Group
	• Quality assurance visits
	• Internal Reviews against External National Reports
	• Getting it Right First Time (GIRFT)
	• Localised deep dives, reports and action plans
	• Operational grip on workforce gaps
	• Patient Advice and Liaison Service Activity
	• Comprehensive Cultural Competence training and awareness
		• Operational oversight of sustainable change, evidence of learning and improvement measures
		• Harm review process to be approved for the planned care major change programme
			Management:
			• Learning from deaths Report to QC and Board
			• Quarterly Strategic Priority Report to Board.
			• Divisional risk reports to SRG bi-annually.
			• Guardian of Safe Working report to Board
			• Quality and Governance Reporting Pathway.
			Quality Safety and Experience Committee reports include:
			  ○ Safeguarding Annual Report to QSE
			  ○ Infection Control Annual Report
			  ○ Health and Safety Annual Report
			  ○ Bimonthly Quality Report
			  ○ Deep dive Reports
			  ○ Risk Management Report
			  ○ Integrated Performance Report
			  ○ Duty of Quality annual report
			
			Risk and compliance:
			• Quality Dashboard
			• Duty of Candour
			• Corporate Risks
			• Ombudsman Annual Letter
			
			Independent assurance:
			• Health Inspectorate Wales Reports
			• Care Inspectorate Wales Reports
			• Coroners' reports:
			• Internal Audit reports. Patient Experience –Reasonable
			• Royal College Reports
				Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty
				
				All actions on track or closed
				
				• Nursing & Midwifery Vision Embedding (launched May 2025)
				• Allied Health Professional Strategy
				• Clinical services plan
				• Harms review process to be approved for planned care
					Limited Assurance

Appendix 1 – Board Assurance Framework October 2025.

			• Llais Reports • Ombudsman Screening Quality Assurance Services assessments and reports of: • Antenatal and New-born screening • Breast Cancer Screening Services • Bowel Cancer Screening Services • Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; • Pathology (UKAS) • Endoscopy Services (JAG) • Medical Equipment and Medical Devices (BSI) • Blood Transfusion Annual Compliance Report (MHRA) • Ionising Radiation (Medical Exposure) Regulations		

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Civica mapping of services to improve consistency of levels of feedback	Deputy Executive Director of Nursing	Complete	31/03/2025
	Expand real-time feedback systems across all services (SMS texting for priority areas e.g. ED)	Deputy Executive Director of Nursing	Complete	31/12/2024
	Quality Management System in development. – pilots in urology and vascular	Deputy Executive Director of Nursing	Complete	31/03/2025
	Reduced response times for addressing patient complaints.	Deputy Executive Director of Nursing	Complete	31/03/2025
	Learning Repository Development – Delayed due to Digital Team capacity, Digital lead now allocated time to complete and progressing with a revised completion date from 31/12/2024 to 31/11/25	Deputy Executive Director of Nursing	Progressing	31/11/2025
	Harms review process to be approved for planned care activity	Programme Director Planned Care	Progressing	30/11/2025

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of	**Assurance rating**

Appendix 1 – Board Assurance Framework October 2025.

	the risk and reducing the likelihood/ impact of the threat)				the controls or negative assurance)	
Responsible:	Head Of Public Health Assurance & Development	Accountable:	Executive Director of Public Health	Responsible Committee	Population Health & Partnership Committee	
Threat: A widespread loss of organisational focus on investment and support to improve integrated prevention to better population health and wellbeing	• Public Health team and other teams across the HB, working on evidenced based programmes of work which link to National and local priorities • Integrated prevention strategies focused on population health and wellbeing to reduce health inequalities • Continuation of Grant funding confirmed 25/26 • Ministerial Priorities include Prevention and Population Health • Prevention, Population Health and Early Intervention Exec Delivery Group established July 25 will review Corporate and emerging risks. •	• Limited access to timely integrated data supporting prevention activity. • Insufficient integration between prevention and clinical services • Services fail to prioritise prevention as part of the delivery of effective services and outcomes. • Large proportion of budget is non-recurrent grant funding • Diabetes Pathway Programme delivery plans (service level) - dependent on options for change agreement	**Management:** • Regular reports against a range of outcomes from the public health outcomes framework to Planning, Population Health & Partnership Committee • Completion of Audit (Sept 25) in relation to management of Grant funds and dleivery – report to Audit Committee **Risk and compliance:** • CRR24-08 Delivering a population health approach to health and wellbeing and CRR24-18 Outbreak Management reported to Planning, Population Health & Partnership Committee. Corporate Risk Review has resulted in refresh and consolidation of these two risks into one. • Operational Risk Register maintained. **Independent assurance:** • Regular reports against a range of outcomes from the public health outcomes framework to Regional Partnership Board Public Service Boards & Welsh Government • Review held with Welsh Government October 25 – focus on shift to prevention, Health Improvement activity	• Limited assurance of effective models - based on availability of data, intelligence, evidence and evaluation of impact of current prevention approaches within the Health Board and wider partner networks.	**Limited Assurance**

			and health inequalities programmes.		

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Action Handler	Status of Actions	Date when action will be completed
	Increase collaboration with community partners	Strategic Partnership Manager	Complete	31/03/2025
	Strengthen the integration of prevention into service and Health Board planning	Head Of Public Health Assurance & Development	Complete	31/03/2025
	DDAT/Public Health Integrated approach to population health and clinical data and intelligence embedded in Health Board plans	Assistant Director - Data, Intelligence & Insight / Consultant In Public Health Medicine	Complete	30/09/2025
	Diabetes Pathway Programme – completion of case for change and next steps agreed - delay in appointing Clinical Lead however this has now gone out for expressions of interest. There have been some revisions to the plan as a result and also in keeping with wider priority programmes including Primary Care.	Executive Director Of Public Health	Delayed	30/07/2025
	Deliver Primary Care based approaches to improving the compliance with NICE guidance	Service Leads	Delayed	30/10/2025
	Grant funded Programme plans approved by Welsh Government and Public Health Wales	Head Of Public Health Assurance & Development	Complete	30/04/2025
	Prevention embedded in Board Major Programmes	Programme Leads / SRO	Progressing	31/03/2026
	Development of Clinical Services Plan and Health Board Strategy recognises prevention as component part	Consultant in Public Health	Progressing	31/03/2026

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating

Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

Responsible:	Director of Mental Health & Learning Disabilities	Accountable:	Executive Director of Allied Health Professionals and Health Science	Responsible Committee	Quality, Safety and Experience Committee

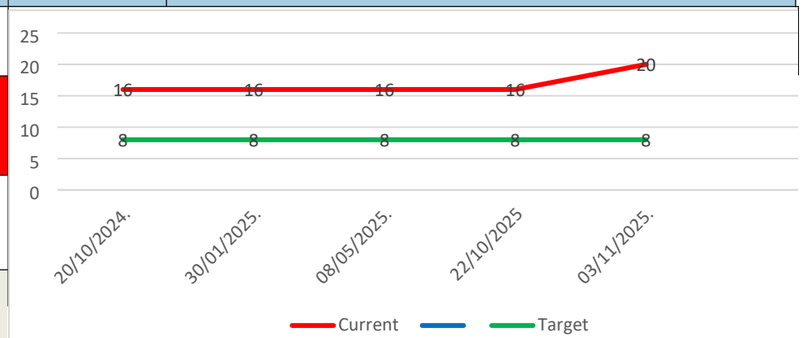
Threat: Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities in the Health Board strategy, planning and operations leading to sub optimal patient outcomes, lack of an holistic approach, regulatory non-compliance and reputational harm.	• Alignment with Welsh Government National strategies for Mental Health and wellbeing, Learning Disabilities and Substance Misuse • Adherence to Royal College and Clinical standards • National NHS Executive Mental Health and Learning Disabilities (MHLD) Strategic Improvement Programme • Established Royal College Psychiatry Improvement programme with Health Board wide reporting and governance • Established reporting through existing HB Governance Frameworks, Oversight committees and routine audits to ensure compliance and monitor progress. • Inclusion in Health Board Annual Plan and monitoring mechanisms • Inclusion in organisational Major change programme, oversight and reporting • Clinically led Physical health work stream in MHLD • Primary care pathways • Crisis Care Concordat in place	• Recruitment and Retention challenges impacting on workforce including interim posts • Engagement and collaboration with physical health services • 'Foundations for the Future' programme maturity • Insufficient focus on health inequalities • Lack of integrated Electronic Health Record and other digital systems • Limited visibility of Mental health and Learning disabilities data at Board level • Current risk to balanced financial position • Greater focus on community and earlier intervention services	**Management:** • External reviews in 2023-24, undertaken as part of Special Measures all recommendations completed and managed. • Performance Management and reporting • Civica and patient reporting metrics **Risk and compliance:** • Compliance with Royal College Standards • Audit Reports **Independent assurance:** • Development of co-produced Patient Carer engagement work • Expert advisory group • External reviews • National and Local performance reporting • Together 4 Mental Health Partnership Board in place	• Lack of integrated patient care records impacting on care, planning and reporting • Increasing the scope of performance reviews focusing on patient pathways. • Improving our real time patient data • Visibility of community mental health activity	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Recruitment plans for substantive workforce.Now- completed,Director of Nursing successfully recruited with anticipated start date 17th November 25. Recruitment activity remains buinsess as usual but progress made across the division and plan now in place.	Director Of Operations MHLD	Complete	31/09/2025
Increased pathways with Primary care	Consultant Psychiatrist/medical Director	Progressing	31/12/2025
Active engagement with the Foundations for the future programme now completed as MHLD formally engage with aspects of the programme and with be Business as usual until FftF is rolled out.	Director Of Operations MHLD	Complete	31/10/2025

Appendix 1 – Board Assurance Framework October 2025.

	Electronic Health Record programme with MHLD as early adopter	Interim Director Mhld	Progressing	31/03/2026
	Enhanced Savings plans	Chief Finance Officer	Progressing	31/03/2026
	Responsive annual plan	Head Of Integrated Strategy And Development	Complete	31/03/2025
	Implementation of Communication strategy, will remain dynamic and developmental	Head Of Integrated Strategy And Development	Complete	31/12/2025
	Alignment with Learning Disabilities national programme- Improving Care Improving lives review	Director Of Operations MHLD	Progressing	31/03/2026

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk** Risk of ineffectively delivering timely access to care resulting in potential clinical harm, poor delivery of performance targets and reputational risk	**Strategic objective**	4. To Improve Quality, Outcomes and Experience 4E: Planned Care; 4F: Cancer Care; 4G: Urgent and Emergency Care; 4H: Diagnostics; 4ICAMHS and Neurodevelopment)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Quality
Risk Lead	Chief Operating Officer	**Risk appetite**	Open <15 Risk Above Tolerance
Related Corporate Risks:	CRR25-01 , Timely Patient Access to Safe and Effective Care		



Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	5	4	**Initial date of assessment**	20/10/2024
Likelihood	4	2	**Last reviewed by Committee:**	12/08/2025
Risk rating	**20**	8	**Last updated by Executive:**	03/11/2025

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**

Responsible:	Interim Associate Director for Emergency Care/ Associate Director of Planned Care/ Professional	Accountable:	Chief Operating Officer	Responsible Committee	Performance, Finance and Information Governance Committee

Appendix 1 – Board Assurance Framework October 2025.

	Service Manager Radiography/ Assistant Area Director – Children					
Threat: The Health Board faces significant risks related to the ability to meet national and local performance targets related to access to timely care. The increased patient acuity, backlog of long waiting times, lack of standardised processes and robust demand and capacity planning at service level may negatively impact the delivery of consistent quality of care. Without strategic planning and robust controls, these risks could lead to reduced public confidence, increased colleague fatigue, ineffective use of resources and failure to achieve regulatory compliance or national standards.	• Initiation of demand capacity plans at specialty/service level • Improved planning including the Winter Resilience Plan with clear principles to protect urgent and planned care pathways • Major change programmes for Urgent and Emergency Care (UEC) and Planned Care • Strengthening preventative support through integrating services such as SICAT and GP out of hours with active community pathways • Strengthening capability and capacity to lead and deliver services with clear executive Senior Responsible Officers (SRO) in place supported by clinical and operational leads • Cancer recovery plan • Planned care delivery plan against the agreed trajectories supported with resource allocations • Diagnostics delivery plan against the agreed trajectories supported with resource allocations • Governance framework for accountability including weekly executive led progress reviews for UEC and Planned Care • Chief Operating Officer and Director of Performance and commissioning collective leadership oversight for operational performance with support from the executive team • Clear workstreams (4) for UEC incorporated into operational planning and delivery as a framework aligned to the national 6 goals for UEC • Optimised hospital flow through SAFER programmes and discharge protocols ensuring resilience to protect planned care pathways • Access to care based on clinical urgency and then chronological wait across all programmes of care • Developing close partnership working with the 6 Local Authorities, Welsh Ambulance Service Trust (WAST), third sector and other providers to maximise care outcomes • Effective utilisation through planning and robust governance for use of nationally allocated resources for planned care and UEC • Regional approach in strategic planning through the Regional Partnership Board ensuring a North Wales approach for delivering services for our citizens	• Clinical variations and lack of standardised operational processes across the Health Board • Limited integration of pathways and care processes between primary, community and secondary care • Insufficient capacity in challenged services and Neurodevelopment • Strategic approach for equipment replacement scheme to ensure service efficiency and sustainability • Estates strategy to address service needs • Challenges in workforce retention and gaps in critical roles affecting service delivery Need for enhanced digital infrastructure to support predictive analytics and proactive planning	**Management:** • Integrated Quality Performance Delivery • Tracking referrals and waiting times • Performance tracking on ambulance handovers • Monthly Performance monitoring • Strategic Improvement Development Groups. • Reviewing consistency in triage processes **Risk and compliance:** • Performance reports to Integrated Performance Executive Delivery Group & Board • Corporate Risk reporting • Patient-reported outcome measures (PROMs) and Patient-reported experience measures (PREMs) data **Independent assurance:** • Internal Audit findings demonstrating substantial assurance • Welsh Government Targets • Joint Executive Team WG • UEC Programme Board with WG attendance • NHS Executive touch points • Significant guidance and steer with National Imaging Programme • CAMHS & Neurodevelopment National Programme links established. National Specification being worked towards. • Regional ND, CAMHs meetings for improvement.	• Independent reviews (focused on areas of concern) • Daily Health Board wide oversight grip in control for UEC performance and reporting • Health Board resource plan for seven-day UEC care model • Health Board workforce plan to align demand and capacity on a seven-day basis • Clear structure and delivery for pathways of care delays for North Wales as a system • Ensuring compliance with Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. • Lack of consistent and reliable performance data at daily and weekly level. • Health Board workforce plan at modality level. • Specific diagnostics assurance process to delivery national patient standard for wait levels. • CAMHS & Neurodevelopment Improvement programme reporting to be defined and governance structure	**Unsatisfactory**

Appendix 1 – Board Assurance Framework October 2025.

			• CAMHS & Neurodevelopment Enhanced Monthly NHS Exec meeting with performance leads.		

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	UEC improvement programme review to ensure the necessary improvements and outcomes are having the required impact on quality and safety of UEC services. Sept midway review. Review of UEC programme completed. New clinically led UEC task team established, with revised priorities agreed with PPHP and NHS P&I	Programme Director, UEC	Complete	30/09/2025
	Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, as a part of workstream one, needs aligning to enhanced community care. Priorities agreed for primary and community transformation led by DPH, EMD and COO	Primary Care Leads	Progressing	31/03/2026
	Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. Review of various dashboards to align input criteria and date. Data quality and alignment to data dictionary review ongoing. Dashboard designs work ongoing. Design phase to be complete by 31/07/2025. Once designed, build and deployment to take place with timescale tbc This is on track	Programme Director UEC/performance team	Progressing	30/06/2026
	Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). Align digital plan to UEC plans. Alignment of plans consistent with revised prioritisation	Programme Director UEC and DDAT team	Progressing	31/03/2026
	Standardising care pathways across the Health Board. Current mapping exercise. Sits within clinical service strategy, community health pathways being rolled out for development in elective care.	UEC task team	Progressing	31/03/2026
	Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. Reinforced with services, complete. To be evidenced in April 2026 through Plans	Head Of Performance / Assistant Director - Data, Intelligence & Insight	Progressing	31/03/2026
	Strengthened workforce planning for key areas linked to challenged services	Operations Manager - Children's Services / Interim Executive Director of Transformation and Strategic Planning	Progressing	31/03/2026
	Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC	UEC task team	Progressing	31/03/2026
	Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. Milestones to be reported	Chief Operating Officer	Progressing	31/03/2026
	Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services)	Chief Operating Officer /Executive	Progressing	31/03/2026

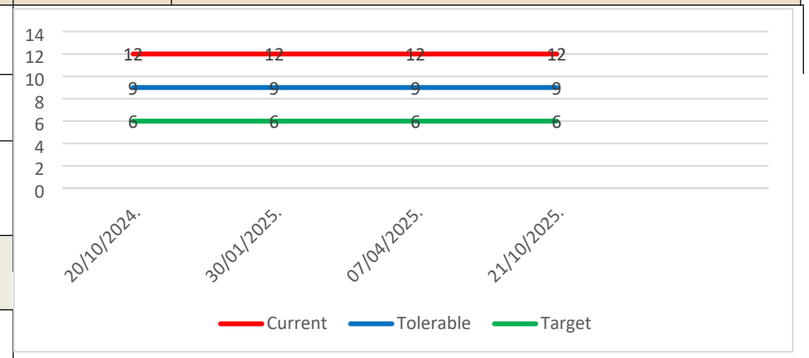
Appendix 1 – Board Assurance Framework October 2025.

		Director of Public Health		
	Regional approach for services such as Child and Adolescent Mental Health (CAMHS)	Associate Director CAMHS - Regional	Progressing	31/03/2026

5: Establishing an effective environment for Learning

Objective area 5 provides opportunity to learn when things don't go as planned, to teach, and to widely use the many sources of information available to us in order to support decision making and knowledge.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-08: Not Implementing Evidenced Based Improvement and Innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care	**Strategic objective**	5: Effective Environment for Learning 5A: University Partnership; 5B: Research, Development and Innovation & 5C: Academic Careers)
Lead Committee	Planning, Population Health & Partnership Committee	**Risk type**	Quality
Risk Lead	Executive Medical Director /Chief Digital & Information Officer	**Risk appetite**	Open <16
Related Corporate Risks:	CRR25-04 Modernising our Infrastructure		



Risk rating			**Review Dates**	
	Current exposure	**Target**		
Consequence	4	4.	**Initial date of assessment**	20/10/2024
Likelihood	3	2	**Last reviewed by Committee:**	21/08/2025
Risk rating	**12**	8	**Last updated by Executive:**	29/10/2025

Board Assurance Framework (BAF): October 2025

Appendix 1 – Board Assurance Framework October 2025.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Assistant Director Data, Intelligence & Insight	Accountable:	Chief Digital & Information Officer		
Threat: Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	• Data collated and available through various systems and software (IRIS/RTT Hub) • Information account Managers to ensure data is interpreted correctly • Some Integrated data analytics and reporting in place • Integrated Leadership Framework & Performance Appraisal and Development Review (PADR) policy, staff development toolkit. • Continuous professional development opportunities for staff	• Regular data analytics reviews and intelligence reports for further assurances • More Assurance on evidence of being intelligence-led • Insufficient integration of data analytics consistently across all service areas • Data driven decision-making framework for services • Limited use of real-time data in clinical decision-making • Inconsistent access to learning opportunities across different service areas • Limited evaluation of the impact of training on service delivery • Limited collaboration on research projects	**Management:** • Monthly data governance reviews • Progress against annual plan to committees • Result of internal data maturity assessment • Utilisation Statistics in IRIS **Risk and compliance:** • Annual reviews of the effectiveness of learning initiatives (OMD) **Independent assurance:** • Clinical body reporting on external evaluations of learning and development programmes (OMD)	• No external evaluation of statistics or use of statistics	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Develop BCU's data warehouse, broadening the range of datasets available. This was a milestone in the Annual Plan 2024/25. Evidence provided on additional datasets created. This now forms business as usual activity as and when new datasets are required.	Assistant Director - Data, Intelligence & Insight	Complete	31/03/2025
Standardise access to learning opportunities for recipient of intelligence products as well as in house team. Additional training provided, with Training Needs Analysis being completed. Once results are returned, a further training programme will be developed.	Assistant Director - Data, Intelligence & Insight	Complete	31/03/2025
Exploring the links with universities on opportunities to work together on data analytics. Contact secured with Bangor, Wrexham and Swansea Universities. Work ongoing to identify potential collaborative projects. Attendance secured at Bangor University careers event October 2025. This now forms part of business-as-usual activity.	Assistant Director - Data, Intelligence & Insight	Complete	30/09/2025

Appendix 1 – Board Assurance Framework October 2025.

	Launch of IRIS2 to improve accessibility and useability of information products.	Assistant Director - Data, Intelligence & Insight	Complete	30/06/2025
	Develop a model for Cancer Referrals and activity for single modality. Work is continuing with cancer services looking at breast pathways. Stage 1 demand for all tumour sites has been assessed against ringfenced capacity to incorporate into Referral To Treatment demand and capacity work, linked to workstream 6 of the Planned Care Programme. We will be working with colleagues from NHS Performance & Improvement to develop the cancer pathway work due to its complexity. Revised due date 30/11/2025.	Assistant Director - Data, Intelligence & Insight	Progressing	30/11/2025
	Refresh Urgent and Emergency Care Winter Plan Model. This work was completed to inform the winter learning debrief event held in August with ongoing forecasting development.	Assistant Director - Data, Intelligence & Insight	Complete	31/07/2025
	Undertake a data maturity assessment for planned and urgent and emergency care to test for improvement from baseline position. Initial assessment undertaken to inform a development plan. Improvements underway related to winter planning and resilience.	Assistant Director - Data, Intelligence & Insight	Complete	30/06/2025
	Development of a Training Needs Analysis and Training Programme for Intelligence Team and also for Planned Care data recipients. Training plan for Data Intelligence and Insight Team in development based on a team-based training needs assessment. Planned care data needs training met through IRIS2 launch events. Ongoing requirements will be monitored through the Planned Care Programme and lead analyst.	Assistant Director - Data, Intelligence & Insight	Delayed	31/10/2025

Responsible:	Associate Director Research & Development & Programme Director – Education Partnerships & Projects	Accountable:	Executive Medical Director		
Threat: Ineffective university partnerships, inadequate joint investment in research, and supporting academic career development to sustain a joint effective environment for learning.	• Some strategic partnerships with academic institutions • Memorandum of Understanding in place with Bangor University and Group Llandrillo Menai.Dedicated governance structure for North Wales Medical School and related projects • Strategic Steering Group in place with Group Llandrillo Menai • Research governance structure • Collaboration with external research bodies and innovation hubs	• Inconsistent engagement with academic partners across all healthcare services • Lack of investment in healthcare innovation projects • Limited career progression opportunities in academia for clinical and non-clinical staff • No Memorandum of Understanding in place with Wrexham University at present	**Timescale: 2025/26** (next update provided will be quarterly milestones based off annual plan)	**Management:** • Clinical Effectiveness Group reporting **Risk and compliance:** • Regular joint project reviews and risk register for projects maintained **Independent assurance:** • External evaluations of projects • Welsh Government Annual review of university designation criteria	• Strategic partnership with Wrexham University and Coleg Cambria being established with a supporting Memorandum of Understanding • Internal governance arrangements and reporting to Clinical Effectiveness Group to be strengthened. • Reporting and monitoring of academic career pathways, assessments of joint academic roles and impact on healthcare delivery	**Limited Assurance**

Appendix 1 – Board Assurance Framework October 2025.

	• All Wales Innovation Pathway deployed				• Commitment to joint investment in research and innovation • Partnership reviews with universities. • Further review of independent assurance requirements	

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Strengthen collaborative research projects with university partners. Draft 'Research Strategy on a Page' developed with Bangor University for consideration by the BU & BCUHB Strategic Steering Group	Associate Director R&D & Programme Director - Education Partnerships and Projects	Progressing	31/03/2026
Strengthen academic career pathways with universities	Associate Director R&D & Programme Director - Education Partnerships and Projects	Progressing	31/03/2026
Increase R&D collaboration with industry and academic institutions	Associate Director R&D & Programme Director - Education Partnerships and Projects	Progressing	31/03/2026
Secure additional funding for healthcare innovation projects	Associate Director R&D & Programme Director - Education Partnerships and Projects	Progressing	31/03/2026
Increase the number of joint appointments between the Health Board and academic institutions	Associate Director R&D & Programme Director - Education Partnerships and Projects	Progressing	31/03/2026

Teitl adroddiad: ***Report title:***	**CORPORATE GOVERNANCE REPORT**			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Audit Committee with an update on key corporate governance matters, offering assurance on the Health Board's compliance with its Standing Orders and broader governance responsibilities. It includes a summary of recent breaches in publication timelines, updates on declarations of interest, and business considered in private sessions now reported publicly, in line with transparency requirements. The report also outlines the Committee's Forward Work Plan, which supports structured and timely oversight, and includes a placeholder for an update on Mental Health and Society.			
Argymhellion: ***Recommendations:***	Members are asked to: • **NOTE** the breaches to the Standing Orders; • **NOTE** the Declarations of Interests; • **NOTE** the Summary of business considered in private session to be reported in public on 21 October 2025; and • **NOTE** the Forward Workplan; and • **RECEIVE** an update on the Mental Health and Society			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger – Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Authors:***	Philippa Peake-Jones – Head of Corporate Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiola

	mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	eth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this. It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is not applicable for this report.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	This is not applicable for this report.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality and less waste
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have effective Corporate Governance can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: • To continue to improve and report on Corporate Governance	
List of Appendices: *Appendix 1 Audit Committee Forward Work Plan*	

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION

The purpose of this report is to provide the Committee with an update on key corporate governance matters.

2. BREACHES AGAINST THE STANDING ORDERS (7.43)

7.43 of the Standing Orders, require that Board members shall be sent an Agenda and a complete set of supporting papers at least 5 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

In terms of the breaches against this requirement in the Standing Orders; there have been 5 instances whereby the full set of Board Papers was not available 5 calendar days before the meeting between the period April and November 2025.

As noted in the Accountability Report 2024/25 a particular focus for 2025/26 is on increasing compliance with the Standing Orders. The delays in the publication of these reports were as a result of further quality assurances to ensure they standards were at an appropriate level.

Board Members have highlighted in their feedback of the Board and Committee meetings that whilst progress has been made in the quality of report writing, there is further work to do. This is part of a programme of development being led by the Corporate Governance Directorate.

3. DECLARATIONS OF INTEREST

As part of the Standing Orders of the Health Board, via the Standards of Business Conduct Policy, declarations of interest must be monitored, they are a critical governance mechanism that supports assurance, accountability, and ethical decision-making. Members and senior staff are required to declare any personal, financial, or professional interests that could influence or be perceived to influence their role in overseeing operations, finances, or strategic decisions. This process enables the Health Board to identify and manage potential conflicts of interest, ensuring that scrutiny and recommendations are based on objective evidence and free from bias. It also reinforces public confidence in the integrity of governance, aligning with national standards and best practice in public sector accountability.

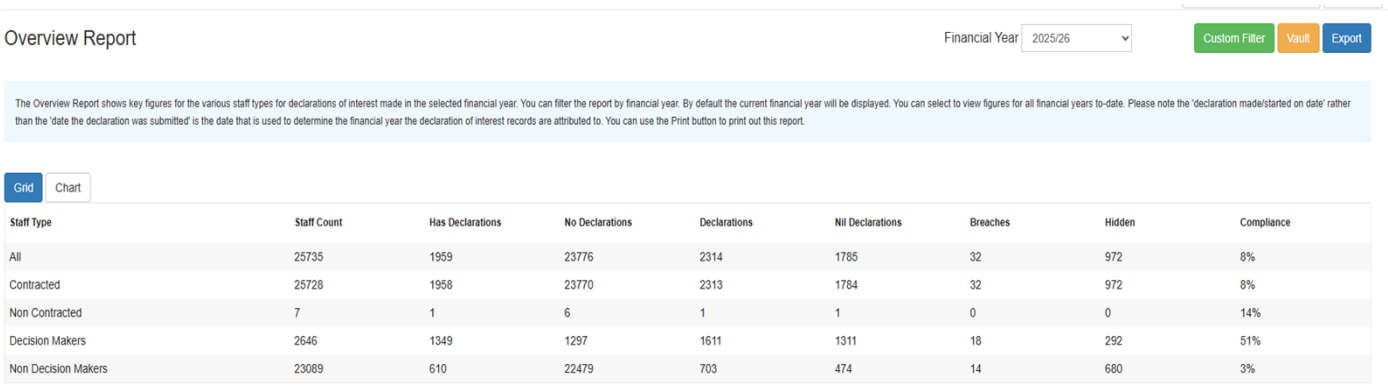
Below are the two registers of interest shared publicly, the first is that of Board Members the second is that of Employees who are 8c and above as defined in the Standards of Business Conduct Policy as those who should declare.

Board Member Declarations can be found:
https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/the-board/register-of-board-members-declarations-of-interest-2025-26-for-the-website-v40pdf/

The current system of reporting declarations of interest and gifts and hospitality is an area of improvement that is highlighted in terms of the Governance Improvement Plan for

2025/26. This information provides a link to the register and going forward, it will be monitored by the Corporate Governance Team reporting on any breaches to the policy.

Declarations for those 8c and above can be found:
https://bcuhb.mydeclarations.co.uk/declarations


Overview Report

Financial Year 2025/26

Custom Filter Vault Export

The Overview Report shows key figures for the various staff types for declarations of interest made in the selected financial year. You can filter the report by financial year. By default the current financial year will be displayed. You can select to view figures for all financial years to-date. Please note the 'declaration made/started on date' rather than the 'date the declaration was submitted' is the date that is used to determine the financial year the declaration of interest records are attributed to. You can use the Print button to print out this report.

Grid Chart

Staff Type	Staff Count	Has Declarations	No Declarations	Declarations	Nil Declarations	Breaches	Hidden	Compliance
All	25735	1959	23776	2314	1785	32	972	8%
Contracted	25728	1958	23770	2313	1784	32	972	8%
Non Contracted	7	1	6	1	1	0	0	14%
Decision Makers	2646	1349	1297	1611	1311	18	292	51%
Non Decision Makers	23089	610	22479	703	474	14	680	3%

4. SUMMARY OF BUSINESS CONSIDERED IN PRIVATE

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

The below items were considered in private at the meeting held on 21 October 2025:

- Local Counter Fraud Service Progress Report
- Corporate Risk Register
- Finance Update

5. COMMITTEE FORWARD WORK PLAN

The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.

6. MENTAL HEALTH AND SOCIETY

As reported to the last Audit Committee the Health Board underwent a procurement to secure an independent review of the arrangements for the Centre For Mental Health and Society (CFMAHS) the successful bidder was unable to proceed with the independent review due to personal reasons. Internal Audit agreed to conduct the review, and it commenced during November 2025. There are some final information gathering meetings in January and the report will be produced in the New Year.

7. RECOMMENDATIONS

Members are asked to:

- **NOTE** the breaches to the Standing Orders;
- **NOTE** the Declarations of Interests;

- **NOTE** the Summary of business considered in private session to be reported in public on 21 October 2025
- **NOTE** the Forward Workplan; and
- **RECEIVE** an update on Mental Health and Society.

Audit Committee – Non-Routine Committee Business Workplan

(1 April 2025 – 31 March 2026)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
21.07.25	Action AC25/70.1 from Audit Committee 08.05.25	Pam Wenger	Clinical Audit Improvement Plan	Clinical Audit Plan to go to QSE in July and come back to Audit Committee to confirm progress.	Joanne Shillingford	Clara Day	16.12.25	16.12.25 Audit Committee agenda item
16.01.25	Audit Committee action AC25/05.4	Audit Committee	Final Internal Audit Report on Consultant Job Planning	Progress and oversight to be monitored by the People and Culture Committee referring back to the Audit Committee in six months' time.	~~Sree Andole~~ Clara Day Nick Graham	Pam Wenger	16.12.25	Considered at P&C Committee14.08.25, Full report and action plan considered at P&CC on 4.12.25 and on Audit Committee agenda 16.12.25
08.01.25	Action AC24/151.1 from Audit Committee	Pam Wenger	Review of Centre for Mental Health and Society (CfMHaS) / Report on FOI Request Email from PM 01.07.25 still in the procurement stage so report not due to be ready until end of August	A full evaluation report to be presented at Audit Committee – this was due to go to Jan / March but put forward for April meeting as the review will be commissioned externally.	Phil Meakin	Pam Wenger	16.12.25	Further work required update provided in the CG Report
29.07.25	Action AC25/32.1 from Audit Committee	Pam Wenger	Information Governance and Records Management	A session on records management to take place with the Executive Committee and come back to the Committee as a substantive item.	Dylan Roberts	Pam Wenger	16.12.25	Being discussed with the DDaT team how to take this forward
07.07.25	Meeting with Pam re: Audit Committee	Pam Wenger	Risk Framework and Risk Procedures	Include Risk Framework and Risk Procedures under the CRR for October meeting.	Nesta Collingridge	Pam Wenger	21.10.25	**CLOSED** Going to Comm in Oct 25
12.09.24	Action AC24/124.3 from Audit Committee	Audit Committee / Pam Wenger	June – Update on new process for policies Email from GD 03.07.25 to confirm there has been a delay in confirming the approval routes for policies / procedures due to HB reporting structures)	Establish a long term review of the process for reviewing policies and procedures.	Glesni Driver	Pam Wenger	21.10.25	**CLOSED** Going to Comm in Oct 25
22.07.25	Email from HSJ / Pam	Helen Stevens-Jones	Partnerships, Engagement and Communication Internal Audit Report	Update against progress on the Partnerships, Engagement and Communication Internal Audit Report	Helen Stevens-Jones	Helen Stevens-Jones	21.10.25	**CLOSED** Going to Comm in Oct 25
04.03.25	Suggested as part of discussion at meeting 04.03.25	Pam Wenger	Standing Orders Reservation and Delegation of Powers	Full review of Standing Orders Reservation and Delegation of Powers	Philippa Peake-Jones	Pam Wenger	19.08.25	**CLOSED** Going to Comm in Aug 25

12.06.25	Email from PW / TA	Pam Wenger	Audit Wales Planned Care Report	Management response on the Planned Care report to be presented to the Committee.	Tehmeena Ajmal Russell Caldicott	Tehmeena Ajmal Russell Caldicott	19.08.25	**CLOSED** Going to Comm in Aug 25
17.06.25	Email from PW / RC	Pam Wenger	Historical Symphony Contract	Paper to be presented in private	Alison Bishop producing paper	Russell Caldicott	19.08.25	**CLOSED** Going to Comm in Aug 25
31.03.25	Email from Danielle Timmins 31.03.25	Danielle Timmins	Counter Fraud Annual Report	Counter Fraud Annual Report to go to Audit Committee in June 25.	Danielle Timmins	Russ Caldicott	24.06.25	**CLOSED** Went to Comm in June 25
16.01.25	Audit Committee item AC25/04	Audit Committee	The Role of Internal Audit	The video developed has been shared at the AC Development Session in Feb 25 and an update to be provided to the April meeting in relation to the Comms plan and revised video.	Glesni Driver Dave Harries	Pam Wenger	30.04.25	**CLOSED** Went to Comm in May 25
16.01.25	Action AC25/10.1 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies Report on overdue policies (not WCDs)	An update on HB Policies and WCDs went to the January meeting. A report focussing on overdue policies to go to the Committee in April.	Glesni Driver	Pam Wenger	30.04.25	**CLOSED** Went to Comm in May 25
25.02.25	Discussion with PW and PPJ re: March 25 agenda	PW & PPJ	Annual Report Compliance with the Corporate Governance Code	PPJ agreed with PW to put this forward from March 25	Philippa Peake-Jones	Pam Wenger	30.04.25	**CLOSED** Went to Comm in May 25

Teitl adroddiad: ***Report title:***	**Conformance Report: Q2 2025-26**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025
Crynodeb Gweithredol: ***Executive Summary:***	This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations. The areas covered in this report are: • **Purchase orders that are non-compliant with SFI's (July – September 2025)** This data set relates to orders being raised after the invoice has been received. Non-compliance for the period is 246 in July, 271 in August and 212 in September 2025. The total 729 breaches during quarter 2 (Q2) is a deterioration compared to 690 in Q2 2024-25. A significant proportion of the orders are for known expenditure such as utilities charges, contractual clinical services and computer licence fees, however, the variable nature of the volume means that retrospective orders are produced. The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales. NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD). During Quarter 2, the number of file notes approved was 32 with a total contract value of £1.1m. • **Single Waivers (July to September 2025)** The number of waivers issued year to date has significantly decreased compared to this period last year. Single Tenders – 6 approved in Q2, compared to 8 last year. Single Quote – 0 approved in Q2, equal to 0 last year. • **Receivables and conformance with payroll procedures** The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.

As at 30th September 2025, there were 3,231 outstanding invoices, totalling £8.8m, of which 585 invoices, totalling £3.5m were less than 30 days old.

The Health Board places great importance on the requirement for accuracy of payments made to staff, and is particularly concerned to ensure that staff are not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected over a period.

For the period July to September 2025 there were 117 staff overpayments, with a gross value of £0.237m, comparable to 110 and £0.209m in the previous Financial Year. Failure to complete forms on time remains the main cause of overpayments (102 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

As at 30th September 2025 the balance outstanding was £1.041m, compared to £1.127m at 30th September 2024.

- **Payables and conformance with Public Sector Payment Policy (PSPP)**

  The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date achievement for non-NHS invoices by number is 97%.

- **Losses and special payments**

  Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

  Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

  Clinical negligence claims are managed by Legal and Risk Services and there were 358 active claims at the end of September 2025. Of these 191 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £272m (before reimbursement from the Welsh Risk Pool).

- **Welsh Risk Pool Penalties – Learning from Events Report**
  Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

  As at 30th September 2025 the number of claims outstanding is 17. This is an increase of 5 in the quarter.

<table>
<tr><td></td><td colspan="4">

- **Contract Procurement Review Update**
  In total 16 finance procedures have been reviewed and updated over the last year and 4 new procedures have been written, approved and implemented. One policy remains outstanding, this is currently being reviewed and updated and will be circulated for wider consultation prior to being presented for approval.

  Contract Register – Development to create a pan-BCU document and records management system for contracts is progressing. The external software solutions company has produced and issued a first draft of a contract register for the Health Board to test and feedback in January 2026. It is currently anticipated that the register will 'go live' in March 2026.
</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Audit Committee is asked to:
1. To note and discuss the below elements of performance
• Purchase orders that are non-compliant with SFI's
• Single Waivers
• Receivables and conformance with payroll procedures
• Payables and conformance with Public Sector Payment Policy (PSPP)
• Welsh Risk Pool Penalties – Learning from Events Report
• Contract Procurement Review Update
2. Approve the Losses and Special Payments (July to September 2025)</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Russel Caldicott, Executive Director of Finance</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">Denise Roberts, Head of Capital, Business Improvement and Compliance</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☒</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td rowspan="2">Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐</td><td>Derbyniol
Acceptable
☒</td><td>Rhannol
Partial
☐</td><td>Dim Sicrwydd
No Assurance
☐</td></tr>
<tr><td>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</td></tr>
</table>

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Management of financial risk of not achieving value for money.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: ***Implementation of recommendations*** • ***The report is for noting and, in the case of losses and special payments, approval***	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Appendix 1: Conformance Report – Quarter 1 (July - September 2025) 2. Appendix 2: Approved Single Tender Waivers between 1st July – 30th September 2025	

Appendix 1: Conformance Report – Quarter 1 (July to September 2025).

Section 1 - Conformance with Procurement Procedures

a) SFI requirements

The Health Board's Standing Orders (SOs), incorporating Standing Financial Instructions (SFIs), set the minimum thresholds for quotes and competitive tendering. These thresholds reflect relevant regulatory requirements, and are summarised in the following table:

Contract Value (ex VAT)	Minimum Competition
<£5,000	At discretion of appropriate Director
£5,000-£25,000	3 written quotations
£25,000-OJEU threshold	4 tenders
Above OJEU threshold (currently £118,133)	5 tenders
Contracts between £500k and £1 million	WG Ministerial Approval for noting *
Contracts above £1 million	WG Ministerial Approval required *

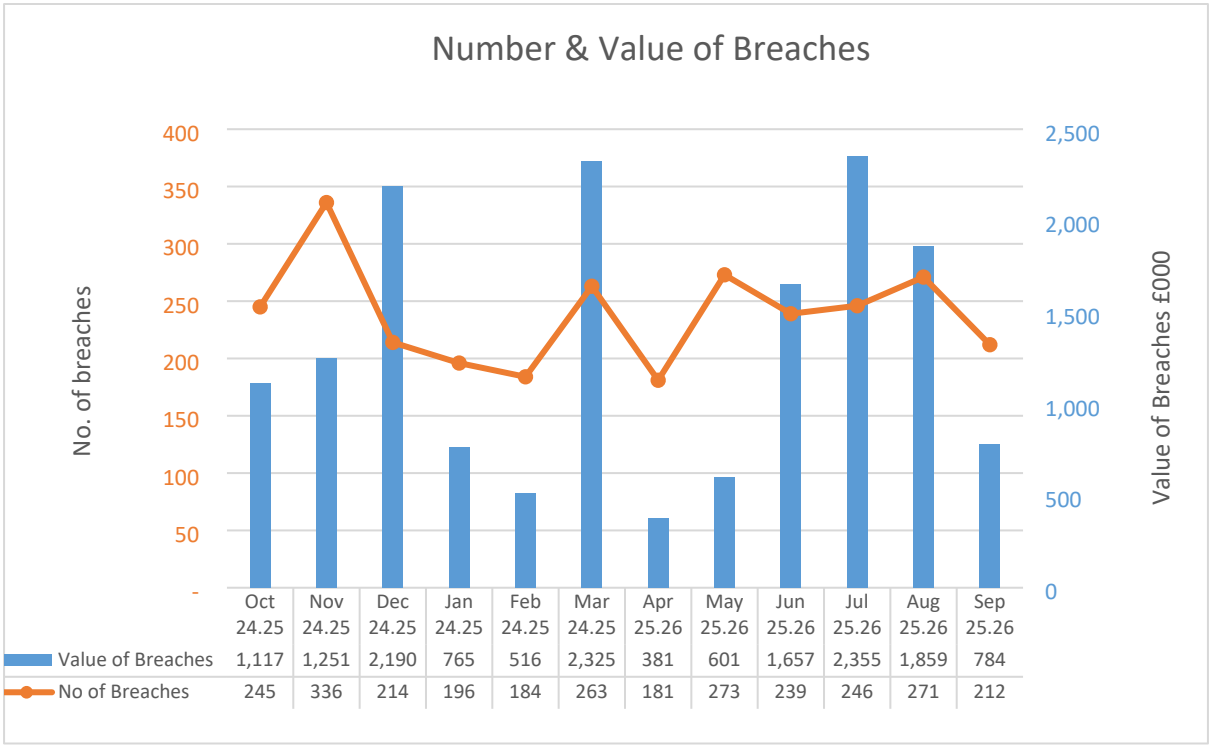
*Exemptions apply (see SFIs)

Compliance with the SFIs promotes effective control, value for money and ensures that the Health Board operates in compliance with relevant legislation.

b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been a 89% increase in the value of Purchase Order breaches in quarter 2 (Q2), with 729 breaches reported with a value of £5.0m. During the same period last Financial Year, the number of breaches were 690 with a value of £4.3m.

The value and number of breaches between October 2024 and September 2025 are detailed below:



The quarterly value of breaches by category are detailed below:

	2024-25				2025-26	
Expenditure Type	Q1	Q2	Q3	Q4	Q1	Q2
Pay (Agency, Fees etc)	494,397	279,110	307,865	393,806	233,105	329,659
Managed Practices	129,987	136,041	115,372	42,796	39,166	179,627
Non-Pay	2,307,822	3,896,810	4,134,814	3,179,579	2,365,783	4,488,975
Total	**2,932,206**	**4,311,961**	**4,558,051**	**3,606,181**	**2,638,054**	**4,998,261**

Of the 'No PO (Purchase Order) No Pay' breaches, the 5 individual orders with the highest value for Q2 are as follows:

Division	Month of Breach	Item Description	PO Amount £000's
Utilities and Rates	Jul-25	ELECTRIC CHARGES FOR GLAN CLWYD HOSPITAL 31/05/2025	264
Utilities and Rates	Aug-25	ELECTRIC CHARGES FOR GLAN CLWYD HOSPITAL 01/07/2025 - 31/07/2025	256
Utilities and Rates	Aug-25	ELECTRIC CHARGES FOR GLAN CLWYD HOSPITAL 01/06/25- 30/06/2025	247
Utilities and Rates	Jul-25	ELECTRIC CHARGES FOR GLAN CLWYD HOSPITAL 01/04/2025-30/04/2025	237
Utilities and Rates	Jul-25	ELECTRIC CHARGES FOR WREXHAM MAELOR HOSPITAL 01/05/2025 - 31/05/2025	221

The Divisions with the highest number of PO breaches have been listed below (£'000s):

Division	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	YTD
Centre	74	108	63	54	43	80	45	76	101	92	112	122	548
East	76	94	55	68	57	66	77	87	67	68	72	77	448
West	80	87	75	37	47	68	53	59	57	60	80	37	346
Regional Services	22	33	20	34	18	36	10	35	21	20	49	20	155
Mental Health & LDS	25	31	20	14	26	11	11	22	17	26	8	27	111

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur. An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Reminder bulletins on procurement rules are issued in procurement communications.

NHS Wales Shared Services Partnership and the Health Board are continuously reviewing processes and resolving 'invoices on hold' issues, through the Accounts Payable function.

NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).

During Quarter 2, the number of file notes approved was 32 with a total contract value of £1.1m. The table below provides detail for each file note:

FILE NOTE REFERENCE NO:	NAME OF SUPPLIER	DESCRIPTION OF GOODS OR SERVICES REQUIRED	REASON FOR BREACH	DEPARTMENT	CONTRACT PERIOD	TOTAL CONTRACT VALUE
2526-013-FN-BCU	LINKEDIN IRELAND	LINKEDN HIRNG CONTRACT RENEWAL 25/02/2025 - 24/02/2028	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	36 MONTHS	£46,125.00
2526-030-FN-BCU	MARGDEN HEATING LTD	HEDDFAN BOILER REPLACEMENT	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	ESTATES	ONE OFF	£11,469.28
2526-049-FN-BCU	XIEL LTD	"C-RAD MAINTENANCE COVER 01/04/25-31/12/25				
CRAD9999-9940 SENTINEL 4DCT SERVICE CONTRACT - 12 MONTHS"			COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	EBME	8 MONTHS	£46,600.00
2526-081-FN-BCU	LEXIS NEXIS UK	LOCAL GOVERNMENT GOLD PACKAGE ANNUAL FEE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	LEGAL	12 MONTHS	£13,995.00
2526-086-FN-BCU	HAAG STREIT UK LTD	PLANNED SERVICING OF HAAG STREIT EQUIPMENT WITHIN BETSI CADWALADR UNIVERSITY HEALTH BOARD	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	EBME	12 MONTHS	£11,642.79
2526-088-FN-BCU	KAPLAN OPEN LEARNING LIVERPOOL LTD	TUITION FEES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PUBLIC HEALTH	ONE OFF	£12,819.68
2526-090-FN-BCU	ACCURX LTD	SMS MESSAGING SERVICE FOR HILLCREST CALL OFF REQ APRIL 2025-MARCH 2026	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	ONE OFF	£7,200.00
2526-092-FN-BCU	GAMA HEALTHCARE LTD	YEARLY EXTENDED WARRANTY & MAINTENANCE FOR CLINELL SCARLETT HPV UNITS	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	ICT	ONE OFF	£11,080.00

2526-095-FN-BCU	APIRA LTD	EDM ONLINE BUSINESS CASE	OTHER (PLEASE ENTER DETAILS IN NEXT COLUMN)	HEALTH RECORDS	ONE OFF	£12,375.00
2526-098-FN-BCU	4S INFORMATION SYSTEMS LTD	DAWN DOSING SOFTWARE MAINTENANCE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	EMERGENCY DEPARTMENT	ONE OFF	£7,322.04
2526-099-FN-BCU	EGTON MEDICAL INFORMATION SYSTEMS LTD (EMIS HEALTH)	SYMPHONY DEVELOPMENT - INVOICE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	ONE OFF	£213,119.85
2526-100-FN-BCU	ACCURX LTD	ACCURX INVOICE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	2 MONTHS	£94,207.43
2526-103-FN-BCU	ROYAL MAIL GROUP PLC	PAYMENT OF COLLECTION INVOICES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	2 MONTHS	£200,000.00
2526-105-FN-BCU	EGTON MEDICAL INFORMATION SYSTEMS LTD (EMIS HEALTH)	EMIS DATABASE SERVICE INTEGRATION	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PRIMARY & COMMUNITY CARE	ONE OFF	£26,610.00
2526-108-FN-BCU	THE ROYAL COLLEGE OF PSYCHIATRISTS	ECTAS MEMBERSHIP RENEWAL- 3 YEAR	EXTENDED WITHOUT APPROPRIATE AUTHORISATION	MH&LD	36 MONTHS	£7,680.00
2526-113-FN-BCU	THE UNIVERSITY OF LEEDS	MASTERS DEGREE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	CHILD & ADOLESCENT HEALTH	ONE OFF	£12,750.00
2526-114-FN-BCU	PATHWAY SOFTWARE LTD	EXTENSION OF THERAPY MANAGER SUPPORT & MAINTENANCE LICENSE AGREEMENT	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	THERAPY SERVICES	12 MONTHS	£176,176.00
2526-116-FN-BCU	MICRONCLEAN	SUPPLY AND LAUNDERING OF CLEANROOM CLOTHING	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PHARMACY	ONE OFF	£6,028.36
2526-117-FN-BCU	THE RENAL ASSOCIATION	UK KIDNEY ASSOCIATION DATA PROCESSING 25 JAN - DEC	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	12 MONTHS	£10,666.25
2526-125-FN-BCU	THE RENAL ASSOCIATION	UK KIDNEY ASSOCIATION DATA PROCESSING 25 JAN - DEC	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	12 MONTHS	£8,130.20

2526-126-FN-BCU	IQUS LTD	ROTAMASTER LICENCES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	GP OUT OF HOURS	ONE OFF	£24,236.91
2526-129-FN-BCU	JAEGER MEDICAL UK LTD	36 MONTH CONTRACT FOR THE MAINTENANCE OF VYNTUS EQUIPMENT	OTHER (PLEASE ENTER DETAILS IN NEXT COLUMN)	EBME	36 MONTHS	£42,465.45
2526-130-FN-BCU	SUPPLY POINT SYSTEMS LTD	12 MONTH CONTRACT FOR THE MIANTENANCE OF MEDIWELL EQUIPMENT	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	MHLD	12 MONTHS	£5,113.00
2526-131-FN-BCU	NOVACOR UK LTD	12 MONTH CONTRACT FOR THE MIANTENANCE OF EQUIPMENT AT DOLGELLAU & BARMOUTH HOSPITAL	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	COMMUNITY HOSPITALS	12 MONTHS	£6,983.10
2526-134-FN-BCU	ADVANCED PEOPLE STRATEGIES LTD	PSYCHOMETRIC TESTING TRAINING	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PEOPLE SERVICES	ONE OFF	£10,055.00
2526-136-FN-BCU	JAEGER MEDICAL UK LTD	36 MONTH CONTRACT FOR THE MAINTENANCE OF VYNTUS EQUIPMENT	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	EBME	36 MONTHS	£21,333.45
2526-137-FN-BCU	BUTTERFLY NETWORK INC	ENTERPRISE WORKFLOW - BUTTERFLY IQ DEVICE SUBSCRIPTION TERM FROM 23/03/25 TO 22/03/28	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	IT	36 MONTHS	£19,200.00
2526-138-FN-BCU	WELSH NATIONAL OPERA LTD	WELSH NATIONAL OPERA FEES FOR 2025 FOR LIVING WELL SERVICE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	LIVING WELL SERVICE	ONE OFF	£8,000.00
2526-139-FN-BCU	THE KNOWLEDGE ACADEMY	CHANGE MANAGEMENT TRAINING FOR 4 INDIVIDUALS	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	GOVERNANCE AND COMMUNICATION	ONE OFF	£6,384.00
2526-142-FN-BCU	POBL TECH LTD	ANNUAL MAINTENANCE AND SUPPORT CONTRACT	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	CHC	ONE OFF	£21,900.00
2526-144-FN-BCU	MEDSTROM LTD	DOLPHIN RENTAL ON FPR FOR 3 MONTHS.	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	DISTRICT NURSING	ONE OFF	£6,120.00

c) *Single Tender Waivers* (for items of expenditure above £25,000)

It is normal practice to request bids from multiple suppliers. Where this is not possible, a single tender waiver should be obtained and approved ahead of expenditure being committed. Allowable rationale for a single tender waiver is:

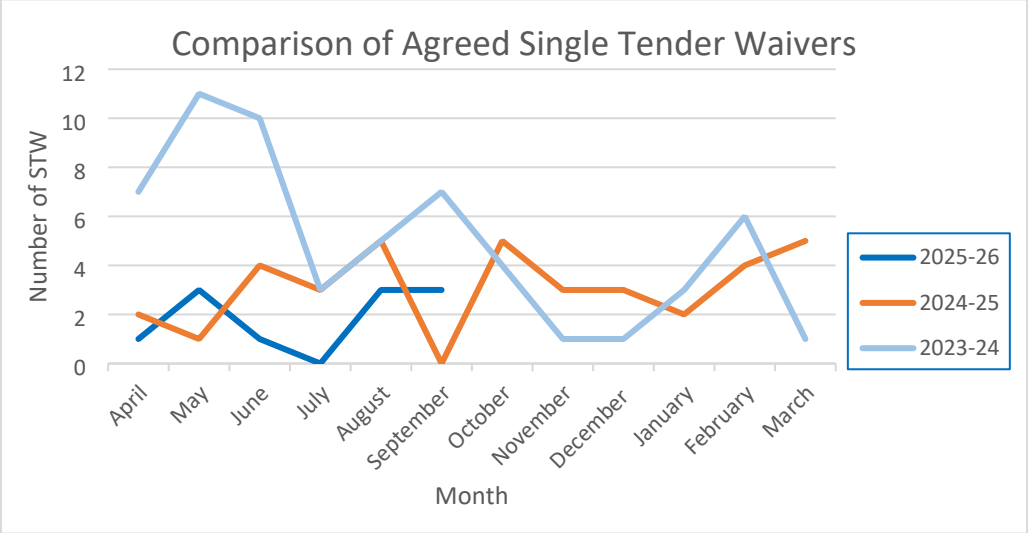
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g., specific equipment required, or compliance with a warranty cover clause;
- A need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

The table below provides a summary of waiver activity for the year and the comparator data of last year.

Single Tender Waiver	2024-25 Q2	2024-25 FYE	2025-26 Q2	2025-26 FYE
Waivers Issued	9	44	16	24
Waivers Approved	8	37	6	11
Value of Approved Waivers	£0.7m	£4.6m	£1.4m	£1.7m
Waivers approval above EU Threshold	0	3	1	2
Cancelled Waivers	1	8	1	3

The number of approved waivers has increased significantly in comparison to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2025-26, compared with 2024-25 and 2023-24. Further information is detailed in **Appendix 1**.



Single Quote Waivers **(for items of expenditure between £5,000 and £25,000)**

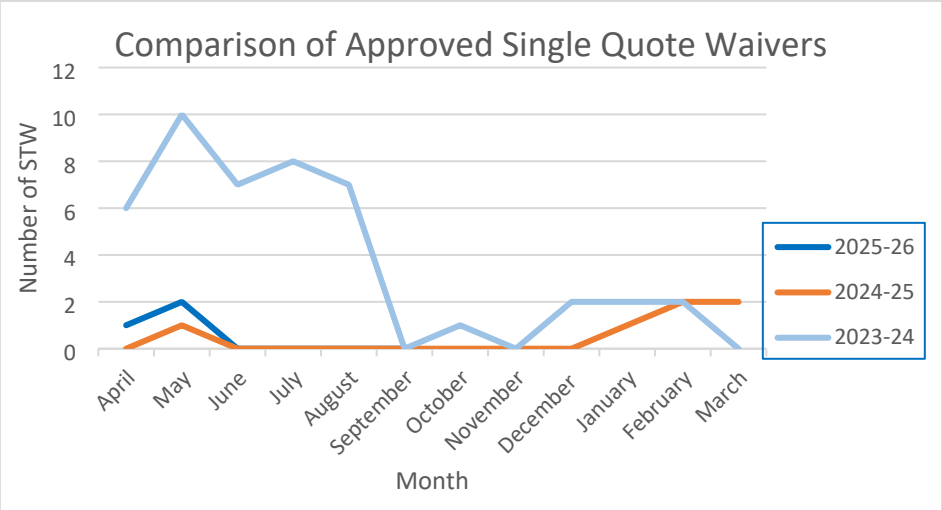
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

The table below provides a summary of waiver activity for the year and the comparator data of last year.

Single Quote Waiver	2024-25 Q2	2024-25 FYE	2025-26 Q2	2025-26 FYE
Waivers Issued	19	60	6	19
Waivers Approved	0	6	0	3
Value of Approved Waivers	£0.0m	£0.07m	£0.0m	£0.03m
Cancelled Waivers	0	0	1	2

The number of approved waivers is consistent compared to the same period last year.

The chart below provides a summary of the approvals to waive quote requirements for 2025-26, compared with 2024-25 and 2023-24. Further information is detailed in **Appendix 2**.



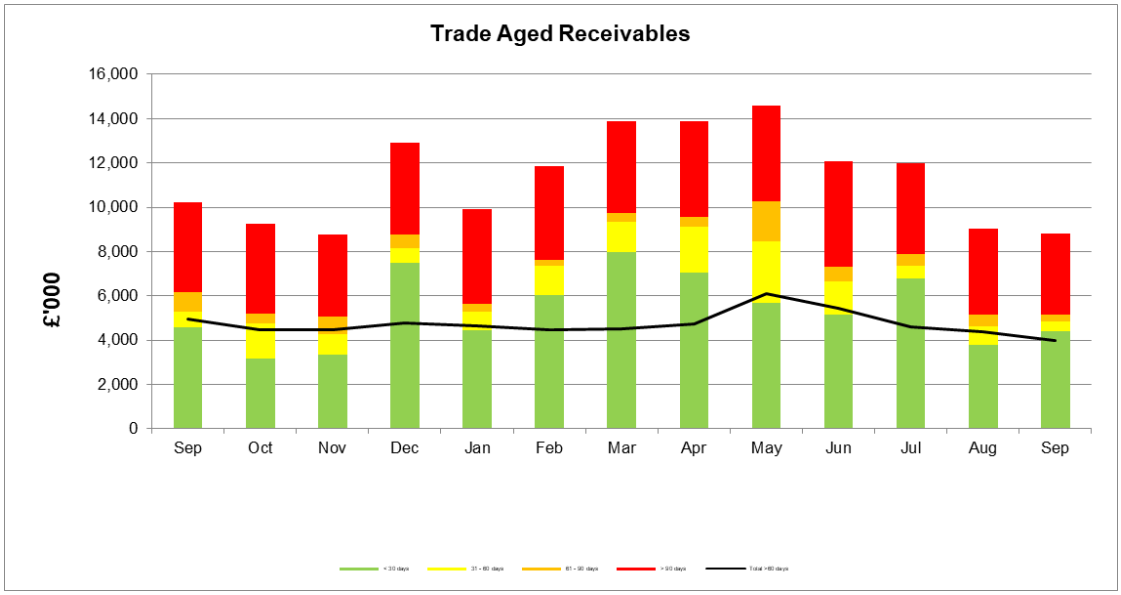
Section 2 – Receivables and Conformance with Payroll Procedures

a) Overview of Balances Owed

The Health Board has robust procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.

As at 30th September 2025, there were 3,231 outstanding invoices, totalling £8.8m, of which 585 invoices, totalling £3.5m were less than 30 days old.

The graph below shows the year-to-date trend in total debt and debt profile.



Provisions for bad and doubtful debts

The Health Board is required to maintain a bad debt provision against each outstanding invoice to cover any future potential write offs. These provisions are calculated as a percentage of outstanding invoice values and are based on the type and value of each debt as well as historic collectability rates. Invoices are subject to further review on a quarterly basis to assess which bad debt provisions need to be increased to 100% due to specific risk of non-payment. All invoices that have been referred to the Health Board's debt recovery agents are automatically subject to a 100% bad debt provision.

Receivable balances over £10,000 and in excess of 6 months old as at 30th September 2025

The Health Board continues to contact a number of NHS and public sector organisations, escalating aged receivables and to seek specialist recovery advice when required. The table below provides an overview of debts over £10,000 and over 6 months old.

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
NHS Cheshire and Merseyside ICB	157	7	Charges were queried by the debtor. BCU Income Team has responded with evidence to support the detail, last chased September 25.	Nov 23 to Feb 25
NHS Greater Manchester ICB	17	1	Part credit actioned to the value of £6k. Payment to be approved and released by ICB for remaining invoice value.	Oct-23
NHS Shropshire Telford and Wrekin ICB	11	1	Invoice consistently being chased by Accounts Receivable with minimal response. ICB are in discussions with BCU Income Team regarding invoice detail.	Oct-24
NHS South West London ICB	13	1	Ongoing query in discussion between ICB and Income Team.	Nov-24
Liverpool Women's Hospital NHS Trust	21	1	Accounts Receivable Team continue to chase.	Mar-25
The Walton Centre	366	14	All queries were responded to by the Income Team and the Accounts Receivable Team continue to chase. Payment received for 5 invoices totalling £95k following reporting date.	May 22 - Mar 25
University Hospital of North Staffs NHS Trust	20	1	Chasing payment through the ELFS Portal. No response received from trust. Last chased September 25.	Mar-25
Connahs Quay Primary Care Resource Centre Management Co LTD	58	1	Practice have confirmed that outstanding invoices have been approved for payment.	Mar-24
Non NHS Company	37	1	Accounts Receivable Team continue to chase. No response received from company. Invoice will be referred to CCI if payment isn't received prior to December 25.	Feb-25
Non NHS Company	15	1	Part payment received. Remaining balance of £1,812.66 continues to be chased.	Mar-25
Non NHS Company	20	1	Accounts Receivable Team continue to chase. No response received from company. Invoice will be referred to CCI if payment isn't received prior to December 25.	Jul-24
Amlwch Health Centre	12	1	Monthly instalment plan agreed.	Apr-14
Cardiff University	14	1	Confirmation received via email that payment has been approved.	Feb-25
Overseas Patient	14	1	Invoice placed on hold until such time that the outcome of Asylum is confirmed.	Jul-24

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
Overseas Patient	20	1	Debt has been referred to CCI, who have instructed International Credit Exchange (ICE).	Aug-22
Overseas Patient	28	1	Debt has been referred to CCI, who have instructed International Credit Exchange (ICE).	Sep-22
Private Patient	10	1	Invoice raised for charge for inpatient treatment has been referred to the patient's insurance company. Accounts Receivable are working with the insurer to obtain payment, contract restraints prevent referral to CCI.	Oct-20
Salary Overpayment	12	1	Debt has been referred to CCI. Repayment plan agreed August 25.	Apr-24
Salary Overpayment	10	1	Awaiting further information from employee regarding affordability. Once received, an appropriate repayment plan will be proposed.	Feb-24
Salary Overpayment	10	1	Instalment plan agreed and accepted, August 25.	Nov-21
Salary Overpayment	16	1	Discussions ongoing between BCU Senior Workforce colleagues. Awaiting further information from the employee.	Feb-22
Salary Overpayment	17	1	Instalment plan agreed and accepted, September 25.	Dec-24
Salary Overpayment	11	1	Awaiting further information from employee regarding affordability. Once received, an appropriate repayment plan will be proposed.	Mar-25
Salary Overpayment	26	1	Overpayment to be recalculated. Awaiting confirmation from NWSSP Payroll.	Jul-23
Salary Overpayment	39	1	Discussions ongoing between BCU Senior Workforce colleagues and Union Representative. Overpayment to be partially offset by basic pay.	Dec-23
Salary Overpayment	10	1	Debt has been referred to CCI. Repayment plan agreed August 25.	Sep-24
Salary Overpayment	12	1	Instalment plan agreed and accepted.	Feb-25
Salary Overpayment	10	1	Debt has been referred to CCI. Repayment plan agreed April 23.	Nov-21

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
Q2 Total	1,464	54		
Q1 Total	1,583	49		
2024-25				
Q4 Total	1,513	41		
Q3 Total	1,230	40		
Movement in current quarter	119	5		

- *St David's Hospice - Agreed repayment plan over a 3-year period*

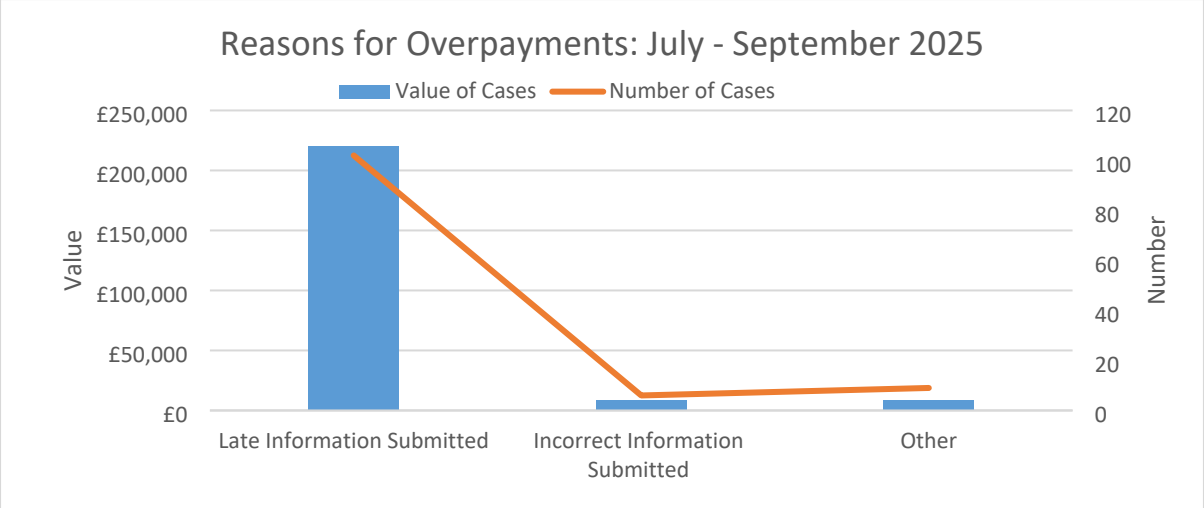
b) Staff Overpayments

The Health Board places great importance on the requirement for accuracy of payments made to staff, and is particularly concerned to ensure that staff are not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected for some time.

	2024-25 Q2	2024-25 PYE	2025-26 Q2	2025-26 FYE
Number of Salary Overpayments	110	273	117	241
Value of Salary Overpayments	£0.209m	£0.622m	£0.237m	£0.510m

For the period July to September 2025 there were 117 staff overpayments, with a gross value of £0.237m, comparable to 110 and £0.209m in the previous Financial Year.

Failure to complete forms on time remains the main cause of overpayments. The reasons for the overpayments are detailed below.



The Establishment Control (EC) team support an establishment control leaver management process.

The specific actions undertaken by the team are:

- Where an Establishment Control request details that a member of staff is leaving, the EC team send a leavers reminder e-mail. This reminds the manager to ensure they action the leaver form and consider items such as an exit questionnaire;
- There is a monthly review of EC requests which details a staff member is leaving. The team compare the details of the staff member noted on the EC request with the ESR Leavers Report and follow up the action with the EC requestor regarding why the team member hasn't moved departments or been terminated;
- The EC Team produces a monthly ESR Leavers Report, which is compared to the ESR Change Event Log by Division. This highlights the number of leavers terminated in ESR after the leaving date and is shared with Division for their information and action.

In addition, staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

It should be noted that overpayments as a result of internal process failures can affect the individual's universal credits, requiring the Health Board to write off the difference to ensure individuals income are not negatively affected.

Staff Overpayment Repayments

A robust and fair approach in the agreement of repayment periods is adopted to recover amounts as soon as possible; however, this can take a number of months especially where the error is attributed to the Health Board and immediate recovery would cause financial hardship.

As at 30th September 2025 the balance outstanding was £1.041m (30th September 2024 £1.127m). The debt, by collection stage, is detailed below:

	No. of Cases	% of Total Outstanding	Value of Total Outstanding
Agreed Instalment Plans	337	51%	£0.391m
Collection Agents	126	19%	£0.245m
In Dispute or Under Review	132	20%	£0.286m
Reminder Stage	40	6%	£0.081m
Invoice Stage	30	5%	£0.038m

The Health Board expects salary overpayments to be repaid either in a single amount or over the period that the overpayment occurred, with a maximum limit of six months. Where individual circumstances would not make this possible, consideration is given to longer repayment periods following completion of a household income and expenditure account. Repayment plans in excess of six months are reviewed with the debtor on a regular basis.

The extremely aged debts are there because either:

- Former organisations agreed the repayment plans, or
- The HB is bound by legal orders applied on judgement, or
- Senior officers agreed plans over the normal maximum repayment period of 36 months.

NHS Wales Shared Services Partnership has approved and issued an All Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments. The procedure is due to progress to the People and Culture Committee for endorsement.

Section 3 - Conformance with Losses and Special Payments Procedures

Losses and special payments should be exceptional in nature and, where they do arise, are subject to additional scrutiny and reporting to the Audit Committee. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

The losses and special payments table below provides an overview of the losses incurred to September 2025. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 358 active claims at the end of September 2025. Of these 191 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £272m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

47% of the caseload (167 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

Year claim registered	No of claims
2025/26	54
2024/25	81
2023/24	60
2022/23	51
2021/22	32
2020/21	35
2019/20	23
2018/19	12
2017/18	0
2016/17	2
2015/16	2
2014/15	1
2013/14	0
2011/12	1
2010/11	1
2009/10	2
2008/09	1
Total claims	**358**

Losses and Special Payments

	Q3 24/25 £	Q4 24/25 £	Q1 25/26 £	Q2 25/26 £	Latest quarter analysis and further action
Medical Negligence					
Gross cost	7,453,235	6,497,793	6,104,839	7,964,638	
WRPS Reclaim	-6,676,066	-5,764,116	-5,280,925	-7,228,209	Payments were made on 180 cases, of which 17 came under the Redress Scheme.
Net Cost	777,169	733,677	823,914	736,429	
Personal Injury					
Gross cost	44,898	80,174	297,831	64,059	
WRPS Reclaim	0	0	-209,528	-36,000	Payments were made on 43 cases.
Net cost	44,898	80,174	88,303	28,059	
Loss of cash	320	0	0	0	No loss of cash was reported in Q2
Debtors written off	-54	107.146	0	18	A number of small balance write offs have been processed in Q2
Loss or damage to equipment, property and stock	110,970	98,152	87,841	59,265	Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board.
Ex-gratia payments	5,448	12,907	50,541	71,095	Relates to 14 payments for loss/damage of patient's property, 11 employment tribunal and 1 ombudsman payments for delayed and unsatisfactory treatment and 1 payment for reimbursement of private appointment fees.
VERS Payments	0	0	0	0	All payments are approved by the Remuneration Committee.
Total	**938,751**	**1,032,056**	**1,050,599**	**894,866**	

* The Welsh Risk Pool Service administers the risk pooling arrangement for negligence claims and reimburses amounts over £25,000

Section 4 – Welsh Risk Pool Penalties – Learning from Events Report

Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

WRP can levy a penalty of between £2,500 to £25,000 per case, which is recharged to divisions where the LFER or evidence is late. 14 penalties have been applied this year to date costing the Health Board £35,000. The total number of penalties during 2024-25 was 66 at a cost to the Health Board of £165,000.

The Health Board has implemented a new process, approved by the Executive Team in December 2024. As part of the process, data is provided to divisions on a weekly basis to support local recovery of overdue submissions in real time.

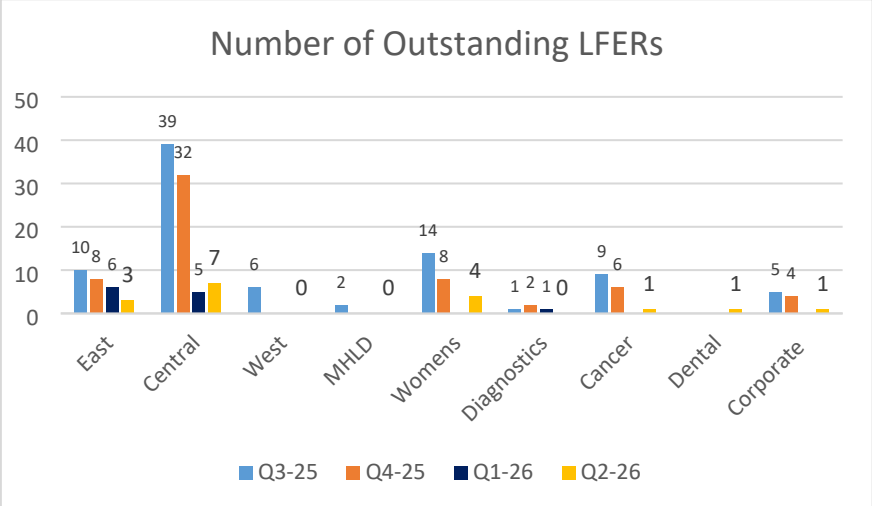
Legal Services hold a bi-weekly meeting to support and scrutinise the division's recovery efforts and performance is reported regularly to the WRP. All divisions have now embedded LFER monitoring into their governance structures.

As at 30th September 2025 the total number of outstanding LFERs was 17 (30th June 2025, 12).

The overdue LFERs, by category and division, are detailed below:

IHC/Division	Claims	Claims Deferred	Redress	Redress Deferred	Total
East	0	2	0	1	3
Central	1	5	0	1	7
West	0	0	0	0	0
MHLD	0	0	0	0	0
Womens	0	4	0	0	4
Diagnostics	0	0	0	0	0
Cancer	0	0	0	1	1
Dental	0	0	0	1	1
Estates	1	0	0	0	1
Total	**2**	**11**	**0**	**4**	**17**

The chart below provides a summary of the outstanding LFER's per quarter:



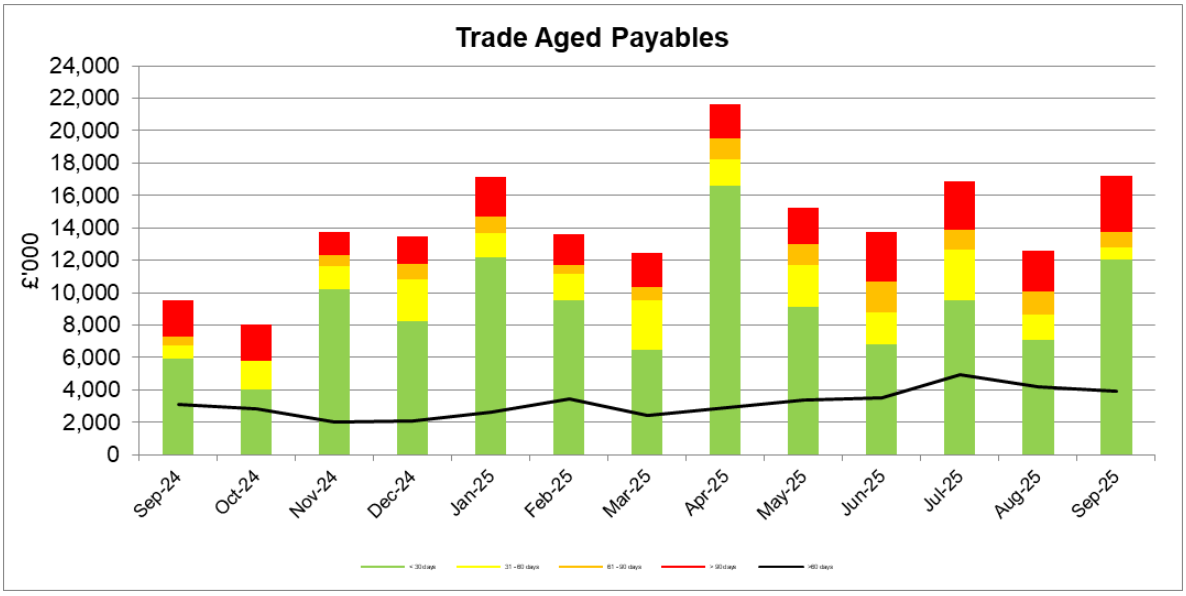
Section 5 - Conformance with Payable Procedures

PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date achievement for non-NHS invoices by number is 97%.

High Value (£10,000 plus) Exceptions

The chart below provides an analysis of the trade payables by month.



The high-value (£10,000 plus) exceptions, over 6 months old, are listed in the table below. High value invoices are reviewed on a monthly basis and action is taken to resolve the disputes/queries.

Payable balances over 6 months old and over £10,000 as at 30th September 2025

Supplier	£000's	No of Invoices	Analysis and further action	Invoice Date
Davita UK Trading Ltd	285	2	Invoices requested to be put on hold - awaiting update from supplier	Feb 25
Flintshire County Council	123	3	Awaiting PO numbers & correction to PO raised without VAT	Jan, Feb & Mar 25
Vantive Ltd	51	4	Invoices have been queried numerous times with the supplier, as yet no response has been received	Apr, Nov, Dec 24 & Feb 25
Medtronic Ltd	45	3	Duplicate invoices, supplier has been contacted requesting credits	Mar 23, Feb 24 & Dec 24
Natural UK Ltd	44	1	Full credit requested; supplier has been re-chased	Jul-24
RMS Imaging LTD	35	2	Shortfall on PO, end user has been requested to raise additional PO	Aug 24 & Sep 24
Treherne Care Services Ltd	37	2	Invoices disputed, the Local Authority is the lead provider for the package of care, the patient was admitted to hospital and 24 hr care provided but no approval was sought.	Sep & Oct 24
Yr Ardd Fadarch Eryri T/A Cyf Ta Madarch Cymru	15	1	Awaiting credit from supplier	Jan-25
Becton Dickson UK Ltd	12	1	Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company is unable to provide PoD due to the length of time. Refer to management for advice	Sep-22
Mindray	12	1	Invoice in dispute with supplier due to equipment being obsolete, awaiting response from supplier as to how to proceed	Mar-25
Funeral Services Ltd T/A CO-OP Funeral Care	11	1	Email sent to end-user to check invoice is valid and to request the correct PO as the one quoted is invalid	Mar-25
Liaison Financial Services Ltd	10	1	Invoice appears to be a duplicate, awaiting company to confirm and issue a credit	Oct-24
SG Fleet Solutions UK Ltd	10	1	Invoice is validated and awaiting payment but as the supplier account is in credit the invoice can't be paid	Mar-25
Stryker Uk Ltd	10	1	Awaiting credit from supplier	Nov-24
Zimmer Biomet Uk Ltd	10	1	Awaiting end user to resolve and correct the PO	Mar-25

Appendix 2 - Approved Single Tender Waivers >£25K between 1st July – 30th September 2025

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Supported By Procurement	Procurement Advice	Breached FTS
2025/2026-1563	04/08/2025	IHC West (Area Team - West)	Pathway Software Ltd	Extension of Therapy Manager support and maintenance licence agreement for BCUHB wide Therapy Services for the period 2025-2026 (budget held West IHC) - this is a delayed submission due to negotiations around the contract between DDATS and Pathway Software Ltd (same price as previous years agreed) Thank you	Follow on from previous waiver	£176,176.00	Reject	Procurement do not support this waiver as it is a retrospective request for payment of invoice. Procurement will contact the department and issue a file note for completion.	2025/2026-1563
2025/2026-1568	18/08/2025	IHC Centre (Area Team - Central)	SupplyPoint	Contract for mediwell maintenance and support cover	Maintenance	£38,595.00	Accept	"Procurement Services support this waiver request due to the sole supplier nature of the requirement. Supply Point Systems are to be deemed as the sole supplier and using a third-party supplier would lead to potential compatibility issues.	2025/2026-1568

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Supported By Procurement	Procurement Advice	Breached FTS
2025/2026-1579	01/09/2025	IHC Centre (Secondary Care - YGC)	NANOG Dental Implant Team	To provide diagnostic Cone Beam CT scan for oral, maxillofacial and orthodontic patients requiring CT images	Interim arrangement pending tender	£31,200.00	Accept	Procurement support the following waiver as an interim arrangement whilst a formal tender process is underway. The waiver will allow a continuation of services to aide in the reduction of patient waiting lists.	No
2025/2026-1580	27/08/2025	Capital	Mace Consult LTD	Project Management Services to deliver Capital Projects	Other (please specify) - The procurement has been supported by SSP. The call-off from a Framework is required to deliver projects with funding recently awarded and insufficient time to tender. Management arrangements in place to ensure value for money.	£179,189.98	Accept	Procurement support the waiver as a compliant NHS SBS framework has been utilised for the direct award and BCUHB's Capital Development team has confirmed capability and capacity to undertake the services.	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Supported By Procurement	Procurement Advice	Breached FTS
2025/2026-1585	09/09/2025	Capital	Amercare	Purchase of 2 x negative pressure isolators as per quote AME10052 Revision 3	Compatibility Issue (eg. warranty cover clause or specific equipment)	£99,624.00	Accept	"Procurement supports this waiver request as Pharmacy have advised that Amercare would be the preferred supplier for multiple reasons.	2025/2026-1585
2025/2026-1594	24/09/2025	Estates and Facilities	Static Systems Group	Replacement of Static Fire Alarm System – Wrexham Maelor Hospital - work to replace network cabling and control panels for the whole site whilst leaving the field devices in situ.	"Other (please specify) - Wrexham Maelor Hospital currently operates a Static Fire Alarm system that has been in place for over 20 years. The system is now obsolete and operates on a closed protocol, meaning only the original manufacturer can maintain, modify, or replace system components. This significantly limits market competition and restricts the ability to source alternative suppliers for the required upgrade.	2025/2026-1594	24/09/2025	Estates and Facilities	Static Systems Group

Teitl adroddiad: ***Report title:***	Post Payment Verification (PPV) Mid-Year Report – 1st April 25 to September 30th 2025
Adrodd i: ***Report to:***	Executive Director of Finance
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025
Crynodeb Gweithredol: ***Executive Summary:***	Mid-year and end of financial year, the PPV Manager will prepare a report for the Health Board Audit Committee to outline how practices have been performing and highlighting PPV progress. It also compares the overall performance of the Health Board against the national PPV visits. The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.
Argymhellion: ***Recommendations:***	It is recommended that the Audit Committee **note** the contents of this report. There are no options included in this report. The report is for Assurance. The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.
Arweinydd Gweithredol: ***Executive Lead:***	Executive Director of Finance
Awdur yr Adroddiad: ***Report Author:***	All Wales Post Payment Verification Manager – Amanda Legge

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch e.g. Health and Safety Executive
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	This report is purely administrative. There are no associated impacts or specific assessments required and is not discriminatory under equality or anti-discrimination legislation. There are no legal implications in the report other than the specifications practices adhere to written and provided by Welsh Government.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith*	The report may include report risks that may have financial implications for BCUHB.

Financial implications as a result of implementing the recommendations	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) (summarise where the paper has been reviewed, the response and what changes have made due to feedback)
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *Excel Audit/Progress Report*	

Audit Committee
16th December 2025
Post Payment Verification Mid-Year Report - 1st April 2025 to 30th September 2025

Introduction/Background

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specifications and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

General Medical Services (GMS): From April 1st – September 30th in 2025/2026 out of 74 visits planned for BCUHB we had 17 in progress and approximately 40 in progress currently. We did not start this financial year's planned work until July which was a national issue and is not specific to any individual Health Board.
We check 100% of the services that have been triggered for a revisit, and these take a long time to finalise. Unfortunately, last year we experienced unexpected absence in the team in a disproportionate number and are in the progress of recovering.
In the first 2 months of this new financial year, we completed all outstanding routine visits that were overdue before we began the new visit plan.
We have begun to undertake the additional verification of Covid and RSV vaccines as requested by Welsh Government which are claimed on the Welsh Immunisations System.

General Ophthalmic Services (GOS): The visit plans for GOS 2025-2026 are progressing well, and as above we did not begin the new financial year until July. More contractors have transferred to electronic patient records so we can undertake the visit remotely, however we do have to carry out elements of physical visits for the contractors who do not have electronic patient records.
We also began verifying claims for an additional 2 services this year for WGOS 4 (Glaucoma and Medical Retina) and IPOS (Independent prescribing) 5 urgent claims.

General Pharmacy Services (GPS): In 2025/2026 we continue to PPV the Collaborative Working Scheme along with the Quality and Safety Scheme which we can undertake remotely.

Additional Services: We have progressed with our quarterly dispensing data checks and have introduced a robust service moving forward into the new financial year, which have resulted in financial recoveries. The results are included in our PPV reports for this year.
Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We are hoping to incorporate these into our GOS visits this year to align to the WGOS reform and the managing of clinical waste.
The PPV team also manage the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.
Quarterly meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.
We are continuing to investigate other avenues for savings from the provision of Clinical Waste services and produce a 'non-collection' report to all our Health Boards.
There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.
PPV training events will continue to be delivered to our Health Boards and contractors when required, including one-on-one training requirements, particularly for new practice staff within the Primary Care setting.

Audit Report - 1st April to 30th September 2025 = Betsi Cadwaladr University Health Board

General Medical Services (GMS) for 2024 - 2025 | **BCuHB = 29 visits were completed with a total of recovery of £54,399.09** | **ALL WALES = 193 visits were completed with a recovery of £216,100.90**

GMS

Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
Routine	30	17	947	£14,716.64	£8,303.03	£23,019.67	103	65	£44,544.91	£57,371.51	£101,916.42
Revisit	45	0	0	£0.00	£0.00	£0.00	148	0	£0.00	£0.00	£0.00
TOTAL	**75**	**17**	**947**	**£14,716.64**	**£8,303.03**	**£23,019.67**	**251**	**65**	**£44,544.91**	**£57,371.51**	**£101,916.42**

General Ophthalmic Services (GOS) for 2024 - 2025 | **BCuHB = 17 visits were completed with a total of recovery of £4,538.33** | **ALL WALES = 100 visits were completed with a recovery of £16,316.67**

GOS

Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
Routine	22	8	58	£1,715.47	164	39	£6,243.53
Revisit	3	0	0	£0.00	11	0	£0.00
TOTAL	**25**	**8**	**58**	**£1,715.47**	**175**	**39**	**£6,243.53**

General Pharmacy Services (GPS) for 2024 - 2025 | **BCuHB = 47 visits were completed with a total of recovery of £13,404.20** | **ALL WALES = 238 visits were completed with a recovery of £48,153.27**

GPS

Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
Q&S Scheme / Collaborative Working Scheme	Routine	47	16	0	£0.00	232	86	0	£0.00
	TOTAL	**47**						

GMS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	% recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries and individual services with 10% or more error rate
Practice 1	Routine	501	51	10.18%	£648.70	£780.00	£1,428.70	Care Homes, DOAC/R and Ukranian Refugees. Duplicate recoveries on Diabetes
Practice 2	Routine	593	218	36.76%	£2,506.45	£161.48	£2,667.93	Care Homes, Minor Surgery, DOAC/R, Warfarin A, Ukranian Refugees and Wound Care. Duplicate recoveries on Flu and RSV
Practice 3	Routine	473	111	23.47%	£2,223.73	£1,346.58	£3,570.31	Contraceptives, MGUS, Minor Injury, DOAC/R, Warfarn A, Wound Care and Gonadorelin. Duplicate recoveries on Gonadorelin, Flu, Learning Disabilities and Imms (Pneumo)
Practice 4	Routine	711	160	22.50%	£921.79	£474.35	£1,396.14	NPT and DOAC/R. Duplicate recoveries on Flu, Imms, Learning Disabilities, NPT and Gonadorelins
Practice 5	Routine	267	56	20.97%	£536.99	£209.54	£746.53	Care Homes, DOAC/R and Warfarin A. Duplicate recoveries on Diabetes, Flu, Imms (Pneumo), DOAC/R
Practice 6	Routine	760	85	11.18%	£1,328.63	£607.21	£1,935.84	Care Homes, NPT, Warfarin A. Duplicate recoveries on Flu, Imms (MenB), DOAC/R and Gonadorelins
Practice 7	Routine	570	40	7.02%	£741.38	£1,776.65	£2,518.03	Homeless, Imms, Warfarin A and Wound Care. Duplicate recoveries on Diabetes, Flu, Learning Disabilities, DOAC/R and RSV
Practice 8	Routine	943	44	4.67%	£1,112.97	£815.46	£1,928.43	Contraceptives. Duplicate recoveries on Care Homes, Gonadorelins, Flu, NPT, DOAC/R and Imms
Practice 9	Routine	In progress						
Practice 10	Routine	1011	32	3.17%	£658.42	£214.96	£873.38	Ukranian Refugees. Duplicate recoveries on Diabetes, Flu, Gonadorelin, Imms, NPT, DOAC/R, RSV and Warfarin
Practice 11	Routine	In progress						
Practice 12	Routine	338	28	8.28%	£765.00	£260.00	£1,025.00	Contraceptives, NPT and Gonadorelin. Duplicate recoveries on Insulin
Practice 13	Routine	809	14	1.73%	£74.17	£0.00	£74.17	Claim recovery under 10% per service - no Duplicate recoveries
Practice 14	Routine	In progress						
Practice 15	Routine	1050	80	7.62%	£1,552.34	£1,273.56	£2,825.90	Contraceptives and NPT. Duplicate recoveries on Flu, Warfarin and Gonadorelin
Practice 16	Routine	In progress						
Practice 17	Routine	416	28	6.73%	£1,646.07	£383.24	£2,029.31	Care Homes, Learning Disabilities and Minor Surgery. Duplicate recoveries on Diabetes, Learning Disabilities, DOAC/R and Warfarin A

Advisory Notes

- The planned visits were sent to the HB for 2025/26 Visit Plan. These are subject to change due to ad hoc visits or closures/mergers.
- All closed visit files have been authorised by the Health Board GMS team with any concerns/issues being addressed.
- The duplicate amount of recovery is due to the practice submitting certain addtional claims for the same patient more than once. This is a new audit check by PPV and feedback and lessons learnt are being shared to reduce these errors.
- The Health Board have been advised of each recovery made in a detailed report and where necessary the Health Board will follow up directly with the practice/Local Counter Fraud regarding any concerns.
- PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise.
- Training/support is given to practices by PPV after their visit when requested.
- Revisits are taking longer than expected due to 100% check of claims, which is expected to have higher claim error rates when checking 100% of claims.
- Revisits are triggered when the claim error % is 10% or over on any individual service in the routine visit sample, it is not based off the % recovery as a whole.
- Recovery % is based off the sample total and the claim errors made. The recovery % may look higher due to a smaller amount of claims being sampled.

GOS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	% recovery	Value of recovery	Breakdown of Recoveries and individual services with 10% or more error rate
Practice 1	Routine	103	3	2.91%	£117.20	Claim recovery under 10% per service
Practice 2	Routine	103	5	4.85%	£207.00	GOS 4 claims
Practice 3	Routine	103	0	0.00%	£0.00	All claims verified
Practice 4	Routine	103	16	15.53%	£516.00	EHEW claims
Practice 5	Routine	103	11	10.68%	£292.00	GOS 4 claims
Practice 6	Routine	103	12	11.65%	£386.00	GOS 4 and EHEW claims
Practice 7	Routine	103	10	9.71%	£116.00	GOS 4 claims
Practice 8	Routine	103	1	0.97%	£81.27	Claim recovery under 10% per service

Advisory Notes

- The planned visits were sent to the HB for 2025/26 Visit Plan. Numbers are subject to change due to ad hoc visits or closures/mergers.
- As contractors are transitioning to electronic records, remote access and physical visits are progressing well

Teitl adroddiad: ***Report title:***	Internal Audit Progress Report 11 October 2025 – 1 December 2025
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	16 December 2025
Crynodeb Gweithredol: ***Executive Summary:***	<u>Progress report</u> The progress report is produced in accordance with: • the requirements as set out within *Global Internal Audit Standard 11.3: Communicating Results.* • the *Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.* The progress report summarises five reviews finalised since the last Committee meeting in October 2025, with the recorded assurance as follows: • Reasonable assurance – three • Limited assurance – two The report also includes a request for the Committee to approve amendments to the 2025/26 internal audit plan.
Argymhellion: ***Recommendations:***	The Committee is asked to: ➢ **Progress report** • Receive the progress report. ➢ **Plan** • Approve the following amendments to the internal audit plan for 2025/26: o Removal from the plan: ▪ Workforce Planning (BCU-2526-23) ▪ Integrated Regional Care Fund (IRCF) Projects (BCU-SSU-2526-35) ▪ Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (BCU-SSU-2526-39) o Additions to the plan: ▪ Major Project Governance and Contract Management Arrangements (BCU-SSU-2526-43) ▪ Centre for Mental Health and Society (BCU-2526-44) ▪ Integrated Audit Plan – Nuclear Medicine (BCU-SSU-2526-45) ▪ Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub (BCU-SSU-2526-46)
Arweinydd Gweithredol: ***Executive Lead:***	Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Dave Harries, Head of Internal Audit, CMIIA Nicola Jones, Deputy Head of Internal Audit, CMIIA

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒		I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan. The Health Board assurance ratings above differ from those agreed across NHS Wales for internal audit opinions and therefore the assurance level has intentionally been left blank.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A other than those relating to individual audit reviews / recommendations.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	N/A other than those relating to individual audit reviews/recommendations.			
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.			

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A other than those relating to individual audit reviews/recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Progress Report is produced independently of management. The Progress report has been shared with the Director of Corporate Governance.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A other than those relating to individual audit reviews.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The progress report is presented according to the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1: Progress report • Appendix 2: Learning – Regulatory Reporting (BCU-2526-11) • Appendix 3: Delivering successful change and benefits realisation (BCU-2526-15) • Appendix 4: Complaints (BCU-2526-13) • Appendix 5: Community services (BCU-2526-17) • Appendix 6: Contract management and procurement review – Corporate Directors (BCU-2526-38)	

Internal Audit Progress Report

Audit Committee

11 October to 1 December 2025

Betsi Cadwaladr University Health Board

Contents

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Introduction

This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2025/26.

Reports Issued

Since the last progress report, five reviews have been issued as final.

Table 1: Summary of final reports issued

Review	Assurance rating	Key issues
Learning – Regulatory Reporting (BCU-2526-11)	Limited	The review identified significant weaknesses in the Health Board's regulatory assurance framework, noting the absence of overarching policies or written controls to guide operational processes and ensure consistent regulatory engagement, compliance, and escalation
Complaints (BCU-2526-13)	Reasonable	The review noted significant improvement in closing complaints within 30 working days since the Health Board entered Special Measures, though several issues were identified relating to response with deadlines, evidence of learning and recurring themes and trends.
Delivering successful change and benefits realisation (BCU-2526-15)	Reasonable	The review highlighted areas needing management attention, specifically that business cases did not consistently include resourcing for benefits leads from both the Digital Data and Technology (DDaT) and service perspectives, and that there is currently no structured process for reporting benefits beyond individual projects and programmes.
Community services (BCU-2526-17)	Reasonable	The review found clear evidence of governance and monitoring across services, with performance data routinely collected and overseen, but highlighted gaps in assurance to the Health Board regarding community services
Contract management and procurement review – Corporate Directors (BCU-2526-38)	Limited	The review highlighted multiple compliance issues with the Health Board's Standing Financial Instructions, notably frequent breaches of the "No Purchase Order, No Pay" rule and use of retrospective purchase orders. Concerns were raised over the use of Direct Call Off frameworks without consulting NWSSP Procurement Services and around contract signing. Training uptake among officers with delegated

		authority was poor despite mandatory requirements, and budget accountability agreements showed poor compliance.

Image 1: Summary of final report assurance ratings issued as of 1 December 2025

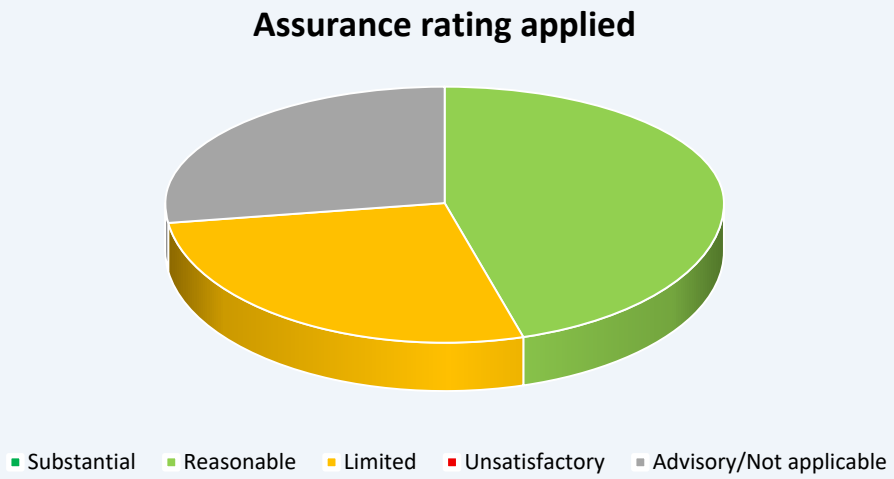


Table 4 details the status of all reviews in the 2025/26 plan.

Follow-up

The Corporate Governance Directorate provide Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure. No actions have been provided for review in the period.

Contingency/Health Board support/Advice

Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.

We have met with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

We have attended and observed the Risk Scrutiny and Executive Policy Oversight Groups in this reporting period coupled with attending/observing the Health Board and its Committees.

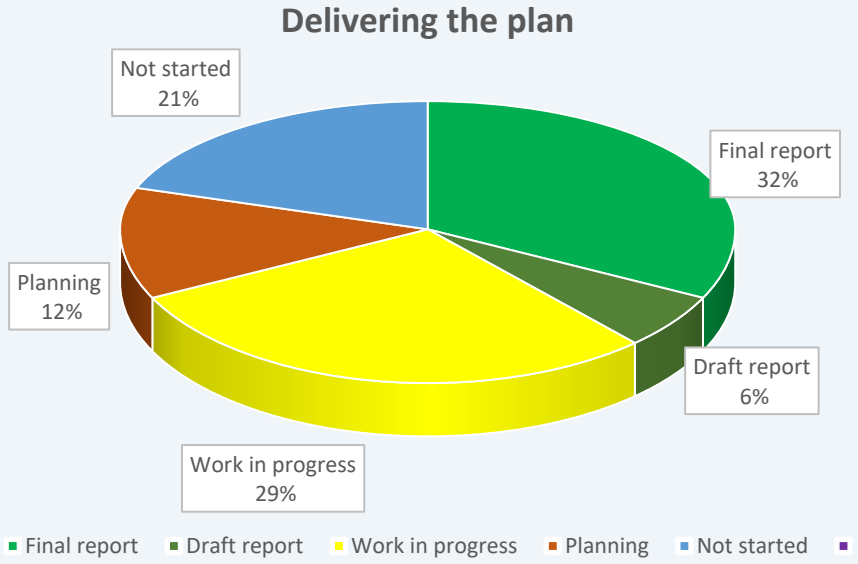
We have met with the Director of Corporate Governance in this reporting period.

Planning for the 2026/27 financial year has started, in partnership with Audit Wales, having already met with or scheduled to meet the Health Board Chair, Committee Chairs and Executive/Corporate Directors.

Delivering the plan

The status of the 2025/26 internal audit plan is detailed in image 2 (excluding proposed additions to the plan).

Image 2: Current status of plan delivery



The additional support provided to the Health Board with focused reviews is channelled through contingency.

As new risks are identified in year, the Director of Corporate Governance and Head of Internal Audit will consider the planned reviews against the emerging high-level risks.

The Audit Committee is requested to approve the changes to the audit plan outlined in the table below.

Table 2: Changes to the 2025/26 internal audit plan

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
Centre for Mental Health and Society (BCU-2526-44)	The Health Board have requested we undertake this review in line with set Terms of Reference. It had received a submission from an external provider who was subsequently unable to complete the review. This will be issued as an advisory report. **Recommendation: This review is added to the 2025/26 internal audit plan.**
Major Project Governance and Contract Management Arrangements (BCU-SSU-2526-43)	The Chief Executive has requested a review of project governance and contract management arrangements in the Health Board. **Recommendation: This review is added to the 2025/26 internal audit plan.**
Integrated Audit Plan – Nuclear Medicine (BCU-SSU-2526-45)	The Health Board is at Final Business Case development and in line with expected controls for major capital projects, there is a requirement to include internal audit review. **Recommendation: This review is added to the 2025/26 internal audit plan.**

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub (BCU-SSU-2526-46)	The Health Board is progressing this project and in line with expected controls for major capital projects, there is a requirement to include internal audit review at the various project stages. **Recommendation: This review is added to the 2025/26 internal audit plan.**
Workforce Planning (BCU-2526-23)	The progress in workforce planning has been delayed due to staff changes within People & OD and the timelines for completion of returns will not enable sufficient time for review and implementation at an operational level resulting in limited information for us to review and test. **Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.**
Integrated Regional Care Fund (IRCF) Projects (BCU-SSU-2526-35)	Due to increased risk to the Health Board emanating from the Nuclear Medicine and Royal Alexandra Hospital (RAH) Health and well-being Hub Integrated Audit Plans, schemes funded through the ICRF cut across several years. Recognising this, we believe this scheme can be recommended for deferral and considered as part of the 2026/27 risk assessment. **Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.**
Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (BCU-SSU-2526-39)	There has been limited progress on this scheme for audit review and therefore we will not be able to provide an assurance report within this financial year. **Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.**

The following tables detail the planned performance indicators (Table 3) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 4).

For 2025/26, six reports have been issued as final, with three missing the response timeline.

Table 3 is reporting a positive status across all indicators except for plan delivery. We have experienced delays in management response to the request for evidence in two reviews. Figures are based on nine reports issued as final for 2025/26.

Table 3: Performance Indicators

Indicator	Status	Actual	Target
Operational Internal Audit Plan agreed for 2025/26		4 March 2025	30 June
Total audit reviews reported against adjusted plan for 2025/26		11	13

Indicator	Status	Actual	Target
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100%	80%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]		64%	80%
Report turnaround: time from management response to issue of final report [10 days]		100%	80%

Key : v>20% 10%<v<20% v<10%

Table 4: Core Plan 2025/26

Planned output	Status	Planned Committee Meeting[1]	Assurance rating
1. Risk Management and Board Assurance Framework (Assurance)	Not started.	April 2026	
2. Follow up	Work in progress.	On-going	
3. Corporate Legislative Compliance - Civil Contingencies Act 2004 (Assurance)	Final report.	October 2025	Limited
4. Standards of Business Conduct (Assurance)	Not started.	April 2026	
5. Executive and Operational Leadership Team Governance (Assurance)	Brief agreed.	April 2026	
6. Public Health: Prevention and Early intervention – Grant funded activity (Assurance)	Final report.	October 2025	Reasonable
7. Value and Sustainability - improvements and savings delivery (Assurance)	Draft report.	October 2025	
8. Budgetary Control and Financial Reporting (Assurance)	Deferred.		
9. Budget Setting (All Wales review) (Assurance)	Work in progress.	February 2026	
10. Patient Experience (Assurance)	Final report.	October 2025	Reasonable
11. Learning – Regulatory reporting (Assurance)	Final report.	October 2025	Limited
12. Outpatient Transformation (Assurance)	Deferred.		
13. Complaints (Assurance)	Final report.	December 2025	Reasonable
14. Skills and Capabilities (Assurance)	Deferred.		-
15. Delivering successful change and benefits realisation (Assurance)	Final report.	December 2025	Reasonable

[1] Subject to change

Planned output	Status	Planned Committee Meeting[1]	Assurance rating
16. Non-Digital Data and Technology (DDaT) controlled IT (Assurance)	Work in progress.	February 2026	
17. Community Services (Assurance)	Final report.	December 2025	Reasonable
18. Productivity and Efficiency (Assurance)	Deferred.		-
19. Planned Care Major Change Programme (Assurance)	Work in progress.	February 2026	
20. Urgent Emergency Care (Assurance)	Not started.	June 2026	
21. Primary Dental Care (Assurance)	Deferred.		-
22. Primary Medical Care (Assurance)	Draft report.	December 2025	
23. Workforce Planning (Assurance)	Not started.	June 2026	
24. Culture and Leadership Development (Assurance)	Work in progress.	February 2026	
25. Speaking Up Safely (Assurance)	Brief agreed.	February 2026	
26. On-call arrangements (Assurance)	Work in progress.	February 2026	
27. Consultant Job Planning follow up	Final report.	October 2025	Assurance not applicable
28. NICE guidance compliance (Assurance)	Work in progress.	February 2026	
29. Agency utilisation (Assurance)	Deferred.		
30. Challenged Care services (Assurance)	Brief agreed.	April 2026	
31. Estate Management (Assurance)	Work in progress.	February 2026	
32. Statutory Compliance: Asbestos Management (Assurance)	Not started.	April 2026	
33. Capital Systems (Assurance)	Deferred.		-
34. Wrexham Maelor Hospital Engineering Infrastructure Programme (Assurance)	Deferred.		-
35. Integrated Regional Care Fund (IRCF) Projects (Assurance)	Recommended for deferral.	June 2026	
36. Falls Management follow up	Final report.	August 2025	Assurance not applicable
37. Contract management and procurement – Digital Data and Technology (Advisory)	Final report.	August 2025	Advisory
38. Contract management and procurement – Executive and Director corporate functions (Assurance)	Final report.	December 2025	Limited
39. Adult and Older Persons Mental Health Unit at	Recommended	June 2026	

Planned output	Status	Planned Committee Meeting[1]	Assurance rating
Ysbyty Glan Clwyd (Assurance)	for deferral.		
40. Pharmacy regulatory compliance / controlled drugs	Not started.		
41. Sickness management	Not started.		
42. Purchase cards & Petty cash	Not started.		
43. Major Project Governance and Contract Management Arrangements	Work in progress.		
44. Centre for Mental Health and Society	Work in progress.		
45. Integrated Audit Plan – Nuclear Medicine	Recommended for inclusion.		
46. Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub	Recommended for inclusion.		

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Betsi Cadwaladr University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: December 2025

Document reference: 4960A2025

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit Committee update

About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board. We presented our most recent Audit Plan to the committee on 3 March 2025.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Awyr Las Accounts 2024-25	Russell Caldicott, Executive Director of Finance	Audit of Awyr Las Annual Report and Accounts.	Fieldwork commenced	January 2026.
Audit of Accounts 2025-26	Russell Caldicott, Executive Director of Finance	Audit of BCUHB Annual Report and Accounts	Planning commenced	June 2026

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2025 - core	Director of Corporate Governance / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements. This work will also seek to provide an update on the Health Board's progress in addressing audit recommendations made in previous structured assessment reports.	In clearance	February 2026
Use of the strategic financial assistance provided by the Welsh Government for the period October 2020 onwards	Executive Director of Finance	This audit will encompass a high-level examination of the Health Board's arrangements for using the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020.	Drafting	February 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of quality governance arrangements	Executive Director of Nursing	This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be determined during the audit planning process.	Fieldwork	February 2026
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	Chief Digital and Information Officer	This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork	Spring/Summer 2026
Thematic review of cancer services	To be confirmed	Following on from our recent review of the national leadership arrangements for cancer services, this work will consider: • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services.	Not yet started	Spring/Summer 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment - deep dive review of the arrangements to manage estates	Executive Director of Finance	This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.	Not yet started	Spring/Summer 2026

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication date
Auditor General for Wales Podcasts on the challenges and opportunities facing the Welsh Public Sector	November 2025
NHS Finances Data Tool 2024-25	September 2025
Digital Health and Care Wales – Review of Stakeholder Engagement Arrangements	July 2025
Temporary Accommodation, long-term crisis?	July 2025
Cost Savings Arrangements: A Checklist for NHS Board Members	June 2025

Additional information

7 Exhibit 4 provides information on corporate documents recently published by Audit Wales. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Interim Report 2025-26	November 2025
Estimate of Income and Expenses for the year ended 31 March 2027	November 2025
Equality Report 2024-25	October 2025
Welsh Language Report 2024-25	September 2025

Audit Wales

1 Capital Quarter

Tyndall Street Cardiff, CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

The management response to audit recommendations

Exhibit 23 below sets out the Health Board's response to our audit recommendations.

Recommendation	Management response	Completion date	Responsible officer
Planning R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. (Exhibit 2)	The Health Board has identified Planned Care as a Major workstream (one of four) with the Chief Executive to Chair the Planned Care Project Board that will oversee delivery of the major program with 6 workstreams; 1- RTT Waiting List Management 2- Referral Management 3- Booking 4- Pre-operative and post operative effectiveness 5- Follow ups 6- Integrated Planned (Planned Care, Diagnostics & Cancer) The Planned Care Board will oversee development and implementation of plans.	October 2025	Executive Director of Transformation and Improvement
Demand and capacity R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term	The Operational teams are (in conjunction with the Director of Performance) developing demand and capacity plans to support in year and future modelling of Integrated Medium Term Plans (IMTP).	December 2025	Chief Operating Officer (COO)

Recommendation	Management response	Completion date	Responsible officer
service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).**			
Programme governance and programme business cases R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: 3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).** 3.2 Developing a clear planned care	The Planned Care Board will oversee the development of Planned Care enhanced delivery in 2025/25 (see R1). It is of note that the Planned Care Programme Board is to be Chaired by the Chief Executive, with delivery of improvements through the Executive Director of Transformation and Delivery. In addition, this Committee has Welsh Government membership and will oversee use of the Planned Care Fund totalling £34m. 3.1 to be reviewed in conjunction with the revisions to the Standing Orders and scheme of Reservation and Delegation	October 2025 Plan developed October 2025	Executive Director of Planning, Transformation and Improvement Director of Corporate Governance

Recommendation		Management response	Completion date	Responsible officer
	improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).**	As noted previously	See above	See above
3.3	Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).**	Business Case development is being pursued within the Directorate for Transformation and Improvement, with a Business Case proforma under review.	January 2026	Executive Director of Planning, Transformation and Improvement
3.4	Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).**	The Planning cycle will engage with the wider organisation as an ongoing as opposed to an annual process, this change key in determining the ability of the Health Board to prioritise resources for future financial years, aligning to Strategic Plans.	January 2026	Executive Director of Planning, Transformation and Improvement
Programme Board clinical leadership				
R4	The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by:	Programme Board formed and appointments / governance and oversight of the leadership with progress in regards to appointment of clinical leads continuing		

Recommendation	Management response	Completion date	Responsible officer
4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).**	Clinical Director of Planned Care appointed and remit clarified within the Programme Boar.	August 2025	Chief Executive Officer
4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).**	Progress made in appointments for Clinical leads, further appointments to be completed.	December 2025	Chief Executive Officer
Risk management R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months (Exhibit 3).	The Planned Care corporate risk has been reviewed recently including a revision of the description and mitigating actions. A Programme Director appointed to monitor delivery and report on performance and operational delivery the responsibility of the Chief Operating Officer.	October 2025	Executive Director of Finance & Chief Operating Officer
Monitoring impact of additional funding **R6** The Health Board should strengthen its monitoring of the use and impact of the additional	Planned Care Fund utilisation is reported within the Planned Care Program Board, with allocation and use supported through the Integrated Performance, Executive Delivery	Ongoing	Executive Director of Finance

Recommendation	Management response	Completion date	Responsible officer
Welsh Government planned care funding (Paragraph 24).	Group and the Performance, Finance and Information Governance Committee.		
Efficiency and productivity R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should:	The below improvements are contained within the overall planning. These workstreams referred to in section R1 will deliver against the specific elements listed below;		
7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).**	Speciality demand and capacity plans to include reference to GIRFT and optimum levels of performance (access and quality of care) for our local population. This will feature within the demand and capacity modelling.	December 2025	Chief Operating Officer
7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).**	Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling.	October 2025	Chief Operating Officer
7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand	Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling.	October 2025	Chief Operating Officer

Recommendation		Management response	Completion date	Responsible officer
	and address the root cause of surgical cancellations **(Exhibit 6).**			
7.4	Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).**	Theatre optimisation and outpatient efficiency sit within the Planned Care Major Change Programme, which include a set of agreed actions relating to pre-assessment, planning and booking, on the day productivity and follow up protocols. Efficiency and productivity measures including virtual appointment have been developed in appropriate specialities for example teledermatology	November 2025	Chief Operating Officer
7.5	Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).**		November 2025	Chief Operating Officer
7.6	Develop job planning policy and guidance **(Exhibit 6).**	Reporting to Planned Care Programme Board, the newly appointed Executive Medical Director will lead in this area.	December 2025	Executive Medical Director
7.7	Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align	A rolling process of review will be put in place.	January 2026	Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
consultant capacity to meet service demand **(Exhibit 6).** 7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).**	Treat in turn is a key element of delivery of improved access for routine patients waiting an extreme amount of time. Pooled lists for BCUHB and then booking based on treat in turn essential as we look to deliver improved access to our local population. Initially we would look to complete this during 2025/26. However, Foundations for the Future will support delivery through changing operational structures.	November 2025	Chief Operating Officer
Promote, Prevent and Prepare for Planned Care policy R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7).**	Work has progressed in regards to development of the '3P's' for the Health Board, the policy being developed at this time. Work to continue into 2025/26 and complete in the later quarter of the financial year.	November 2025	Chief Operating Officer
Risk of harm R9 In order to strengthen its arrangements for managing the clinical risks associated with			

Recommendation	Management response	Completion date	Responsible officer
long waits, the Health Board should:			
9.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).**	This methodology is currently being worked on with the Executive Director of Nursing.	October 2025	Executive Director of Nursing
9.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**	This is being jointly led by the Executive Medical Director and Executive Nurse Director and following the methodology review will report routinely to the Quality, Health & Safety Committee.	November 2025	Executive Director of Nursing
9.3 Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).**	Plans under development with a focus placed upon challenged specialities.	November 2025	Chief Operating Officer

Archwilio Cymru
Audit Wales

Betsi Cadwaladr University Health Board Charity, Awyr Las - Audit Plan 2025

Audit year: 2024-25

Date issued: November 2025

Document reference: 5141A2025

Contents

This document has been prepared as part of work performed in accordance with statutory functions.

The Auditor General, Wales Audit Office and staff of the Wales Audit Office accept no liability in respect of any reliance or other use of this document by any member, director, officer or other employee in their individual capacity, or any use by any third party.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Introduction

Adrian Crompton

Auditor General for Wales

I am pleased to share my 2025 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 14) sets out how we will ensure those standards of quality are met. Our latest annual quality report, Audit Quality Report 2024, provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

- Assure people that public money is being managed well
- Explain how that money is being spent
- Inspire the public sector to improve

Our vision

- Fully exploiting our unique perspective, expertise and depth of insight
- Strengthening our position as an authoritative, trusted and independent voice
- Increasing our visibility, influence, and relevance
- Being a model organisation for the public sector in Wales and beyond

Our areas of focus

- A strategic, dynamic, and high-quality audit programme
- A targeted and impactful approach to communications and influencing
- A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting and legal requirements and assess whether the Trustee's Annual Report is prepared in line with guidance and is consistent with the financial statements.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and
- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

Planning materiality

Represents 2% of gross expenditure based upon 2024-25 draft financial statements.

£35,920

Reporting threshold (trivial)

Represents 5% of materiality.

£1,800

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Related party disclosures – transactions with Betsi Cadwaladr UHB

£10,000

Related party disclosures – transactions with other parties

£1,000

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Control environment at Fund Manager - Brewin Dolphin

As part of our investment review, we are required to assess the design and implementation of controls within the financial systems operated by the Fund Manager, Brewin Dolphin.

We have obtained the Brewin Dolphin 'Assurance Report on Internal Controls over Custodial Services' for the period 1 November 2023 to 31 October 2024, prepared by PwC. This report includes qualified audit opinions on certain controls in place at Brewin Dolphin.

Additionally, we have received a bridging letter from Brewin Dolphin covering the period 1 November 2024 to 31 March 2025, confirming that there have been no changes to the control environment since the PwC audit.

A qualified control report was also issued on Brewin Dolphin's internal controls last year. We must consider the implications of the current year's

qualification issues on our audit approach and perform targeted audit procedures to address these matters.

Our planned response:

My audit team will:

- understand the qualification matters identified by PWC;
- assess the impact of the qualifications on the assurances gained from the Brewin Dolphin investment information; and
- undertake specific work to address the areas of concern

Misclassification of donations between unrestricted and restricted funds

During the 2023–24 audit, we identified a material amount of donations intended for specific purposes, therefore classified as restricted, that had been incorrectly recorded as unrestricted donations.

Following the audit, an immaterial residual balance of £31,200 remained unreviewed. We recommended that the Charity examined these donations during 2024–25 to identify any further misclassifications and amend their treatment accordingly.

There is a continuing risk that donations may be incorrectly classified in the 2024–25 accounts, potentially resulting in a material misstatement.

We also advised the Charity to review its processes and controls for identifying terms and conditions attached to donations, to prevent recurrence of such errors.

Our planned response:

My audit team will:

- review the work undertaken during the year on the 2023–24 residual balance;
- assess the processes and controls governing the classification of donations; and
- test a sample of donations received to confirm correct classification as either restricted or unrestricted.

Misclassification of donations between activities

During the 2023-24 audit we identified a material amount of 'Income from charitable activities' that had been incorrectly classified as 'Income from donations and legacies' or 'Income from other trading activities'.

We recommended that the Charity strengthen its controls over the classification of donations to prevent such misclassifications from recurring.

There is a continuing risk that donations may be incorrectly classified in the 2024–25 accounts, potentially resulting in a material misstatement.

Our planned response:

My audit team will:

- review the Charity's controls over the classification of donations to ensure they are robust and effective; and
- test a sample of donations received during the year to confirm they have been correctly classified.

Quality and complexity of working papers

In our Audit of Financial Statements reports for 2022–23 and 2023–24, we noted that the working papers provided to support the financial statements were complex and difficult to follow. This resulted in additional time being required by the finance team last year to ensure the working papers provided a clear audit trail.

There is a risk that the working papers supporting the financial statements may lack clarity or structure, resulting in an insufficient audit trail. This could lead to difficulties in obtaining appropriate audit evidence and increase the likelihood of errors or omissions in the financial statements.

This will be the Charity Accountant's second year in post, and we understand that steps have been taken during the year to improve the clarity and structure of the working papers.

Our planned response:

My audit team will:

- review the draft accounts and working papers on receipt to identify whether there are any issues that could impact on the audit timetable.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning **October – November 2025**	Planning meeting Risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment and controls review Information flows Develop testing strategy Indicative audit fee Draft Audit Plan
Fieldwork **November – December 2025**	Update risk assessment Audit of financial statements to include annual report Complete audit testing Evaluate audit findings Audit closure meeting
Reporting **January 2026**	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Post project learning

Audit fee

In January 2025 we published our 2025-26 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 1.7%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

An additional fee of £14,003 was charged for the 2023-24 financial statements audit due to additional time spent due to issues arising and poor-quality working papers

For 2024–25, the estimated audit fee is £34,159 (2023–24: £39,725), reflecting the ongoing risks identified in the audit plan.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Executive Director of Finance.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

.

Audit team

My audit team will continue to work and engage remotely using technology.

The main members of my team, together with their contact details, are summarised in **Exhibit 2**.

Exhibit 2: My local audit team

Engagement Lead	Matthew Edwards Matthew.edwards@audit.wales
Audit Manager	Michelle Phoenix michelle.phoenix@audit.wales
Audit lead	Philippa Christley Philippa.christley@audit.wales

I can confirm that my team members are all independent of the charity and your officers. I am not aware of any potential conflicts of interest that I need to bring to your attention.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality
Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Teitl adroddiad: ***Report title:***	PUBLIC - Local Counter Fraud Service Progress Report Dec 2025			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 December 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This report consolidates Q1 and Q2 progress for 2025/26, providing assurance on counter fraud activity across BCUHB. The focus remains on prevention, detection, and investigation in line with NHS Counter Fraud Authority standards. No significant new fraud risks have been identified that threaten organisational objectives.			
Argymhellion: ***Recommendations:***	The Audit Committee is asked to consider and note the contents of the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Mr. Russell Caldicott – Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	Mrs Danielle Kerr-Timmins – Head of Local Counter Fraud Service			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Building an Effective Organisation			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The progress against the Local Counter Fraud Service Workplan for 2025/26 will be reported to the Audit Committee and also to Welsh Government in the Counter Fraud Annual			

	Report for 2025/26.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption. Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions. Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	CRR 25-08 Non-Compliance with Regulatory and Legislative Requirement
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No recommendations
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No recommendations
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been subject to Executive review and sign off.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:***	

(or links to the Corporate Risk Register)	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Next Steps: The Committee is required to note the contents of the Local Counter Fraud Service Progress Report.	
List of Appendices:	

AUDIT COMMITTEE, 16th DECEMBER 2025

Local Counter Fraud Service Progress Report

1.0 Overview

During the reporting period, counter fraud activity has focused on prevention, detection, and investigation in line with NHS Counter Fraud Authority (NHSCFA) standards. No significant new fraud risks have been identified that threaten organisational objectives. Efforts continue to progress the development of a full organisational fraud risk assessment.

2.0 Casework Summary

	2024-2025 Total	Year to date (2025-2026)
New Referrals	40	30
Cases Closed	35	33
Loss Identified	None Recorded	£17,725.51
Loss Prevented	None Recorded	£169,734.17
Loss Recovered	None Recorded	£13,275.95
Risk Reviews	9	12
System Weakness Reports	0	5
Local Proactive Exercises	0	3

3.0 Prevention & Deterrence

Fraud awareness training compliance: 90.24%

Updated fraud awareness materials issued and intranet content refreshed.

Reviewed key policies (recommendations made and actioned for fraud proofing within policies)

4.0 Observations

Significant improvement in proactive detection and prevention compared to last year. Financial recovery remains modest but prevention figures demonstrate strong deterrence impact. No emerging fraud patterns identified locally; national alerts monitored.

5.0 Conclusion

Counter fraud activity remains effective and aligned with NHSCFA standards. Continued focus on proactive exercises, risk reviews, and staff engagement is recommended.

The Audit Committee is asked to note the report and support continued fraud awareness across the organisation.

6.0 Other / Budgetary / Financial Implications

There are no budgetary implications associated with this paper.

7.0 Equality and Diversity Implications

Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption